

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8501 HARCOURT RD INDIANAPOLIS, IN 46260		
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005400</p> <p>Survey Date: 2/12/2013 through 2/13/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/21/13</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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S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on document review and staff interview, the facility failed to comply with all applicable state laws for 1 of 1 unlicensed surgical technician's employee file that was reviewed.</p> <p>Findings include:</p> <p>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of employee #14's employee file indicated that he/she</p>	S000010	<p>S010 The Surgery Center will apply within three (3) business days, from the date of hire of an unlicensed person involved in direct patient care, for a copy of the person's state nurse state nurse aide registry report and a limited criminal history from the Indiana central repository for criminal history. We will also do a check on the ISDH e-verification site for evidence of prior corrective action concerning this person. The Director of Nursing for the Surgery Center will be responsible for the overseeing of this action. A policy stating the above will be brought before the Executive Board for approval at the 2 nd quarter meeting</p>	03/21/2013			

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	<p>was hired on 3/28/2011 as a surgical tech and employee #3's file lacked documentation of a nurse aide registry report. The surgical tech was not certified.</p> <p>3. At 1:15 PM on 2/12/2013, staff member #1 indicated he/she was unaware that a state nurse's aide registry report was to be ran on all unlicensed and non-certified health care personnel that have direct patient contact.</p>				

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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on documentation review and staff interview, the facility's Governing Board failed to review quarterly reports from the Quality Assessment and Improvement, Risk Management of Radiology Services and Nursing Services for one quarter of 2012.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Governing Board By-laws, last approved February 2012, indicated The Indiana Hand to Shoulder Beltway Surgery Center will hold 4 meetings per year. 2. The surgery center meetings were reviewed for 2012. The 	S000110	<p>S110 The Executive Board will review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow up. The Director of Nursing for the Surgery Center will be responsible for the overseeing of this action. The quarterly meeting will be scheduled closes to the beginning of the quarter in order to leave adequate time if the meeting needs to be rescheduled later in the quarter. This action will be monitored for the next four (4) quarters for compliance</p>	03/21/2013			

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	<p>surgery center conducted three Governing Board meetings in 2012: 4/4/212; 7/25/2012; and 11/2/2012. The first quarter of 2012 lacked a meeting by the surgery center's Governing Board.</p> <p>3. At 11:50 AM on 2/13/2013, staff member #1 confirmed the three (3)surgery center's Governing Board meetings for 2012. The staff member indicated the 1st quarter of 2012 was lacking a surgery center meeting.</p>						

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 3 services provided by contractors were included in its comprehensive quality assessment and improvement (QA&I) program: Housekeeping, Maintenance, and Pest Control.</p> <p>Findings included:</p> <p>1. Quality Assessment/Performance Improvement Policy #0300, last reviewed December 2010, indicated all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. The Quality Assessment</p>	S000310	<p>S310 The QAPI committee will meet quarterly to review all contacted services including housekeeping, maintenance, and pest control. The audits for these services will be revised to have a more in depth review. The Director of Nursing for the Surgery Center will be responsible for the creation of a QAPI review worksheet to be used for these services. These worksheets will be reported as part of the QAPI committee meeting starting with the 2 nd quarter meeting of 2013.</p>	03/21/2013			

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	<p>program indicators were reviewed with staff member #1 at 11:00AM on 2/13/2013. Contracted companies that provide housekeeping, maintenance, and pest control services were not evaluated by the Quality Performance and Improvement Committee.</p> <p>3. At 11:50 AM on 2/13/2013, staff member #1 confirmed housekeeping, maintenance, and pest control contracted services were not monitored by the Quality Assessment/Performance Improvement committee.</p>				

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S000320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and staff interview, the facility failed to ensure Discharge Planning and Reportable Events were included in its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Quality Assessment/Performance Improvement Policy #0300, last reviewed December 2010, indicated all service with direct or indirect impact on patient care quality shall be reviewed under the quality</p>	S000320	<p>S320 The QAPI committee will review all functions, including, but not limited to, the following: discharge and transfer, infection control, medication errors, and response to patient emergencies. Discharges and reportable events will be added, monitored, and reported to QAPI committee for audit. The Director of Nursing will be responsible for overseeing this action. This reporting will begin at the 2 nd quarter meeting</p>	03/21/2013			

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	<p>improvement program.</p> <p>2. The Quality Assessment program indicators were reviewed with staff member #1 at 11:00AM on 2/13/2013. Discharge Planning and Reportable Events were not monitored or evaluated by the Quality Performance and Improvement Committee.</p> <p>3. At 11:50 AM on 2/13/2013, staff member #1 confirmed Discharge Planning and Reportable Events were not monitored by the Quality Assessment/Performance Improvement committee.</p>				

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S000414	<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 documentation review and staff interview, the facility failed to ensure the Infection Control Committee met quarterly in 2012 for 1 of 4 quarters.</p> <p>Findings included:</p> <p>1. The Governing Board By-laws agenda for meetings held in 2012</p>	S000414	<p>S414 The Executive Board will review, at least quarterly, to monitor and guide the Infection Prevention Program in the Surgery Center. The Director of Nursing for the Surgery Center will be responsible for the overseeing of this action. The quarterly meeting will be scheduled closer to the beginning of the quarter in order to leave adequate time if the meeting needs to be rescheduled later in the quarter. This action will be</p>	03/21/2013

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	<p>included Infection Control. The Governing Board By-laws, last approved February 2012, indicated The Indiana Hand to Shoulder Beltway Surgery Center will hold 4 meetings per year.</p> <p>2. The surgery center meetings were reviewed for 2012. The surgery center only conducted three Governing Board meetings in 2012: 4/4/212; 7/25/2012; and 11/2/2012. The first quarter of 2012 was missing a meeting by the surgery center's Governing Board.</p> <p>3. At 11:50 AM on 2/13/2013, staff member #1 confirmed the surgery center's Governing Board meetings for 2012. The staff member indicated the 1st quarter of 2012 was lacking a surgery center meeting.</p>		monitored for the next four (4) quarters for compliance				

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S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on interview, facility housekeeping guidelines, and policy and procedure review, the infection control committee failed to ensure the contracted housekeeping staff used the proper cleaning products and procedures when cleaning the operative areas.</p> <p>Findings included:</p> <p>1. At 2:05 on 02/13/13, the contracted housekeeping staff member #A19 was interviewed regarding the cleaning process for the surgical areas. He/she indicated training was provided by the company, not the facility, and facility staff did not observe the cleaning process. He/she indicated one mop head was used for the entire surgical area and mopping was done in the procedure room and instrument room (both clean and soiled</p>	S000432	<p><u>S432</u> The Infection Prevention Committee will ensure the cleaning and disinfection of the Surgery Center and oversee the contracted housekeeping staff and their use of the proper cleaning products and procedures when cleaning the peri operative areas. The Director of Nursing will be responsible for overseeing this action. Policies will updated, further training of housekeeping staff, as well as the use of QAPI audit tools to ensure policies and guidelines are being followed. This reporting will begin at the 2 nd quarter meeting of 2013.</p>	03/21/2013

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	<p>areas) before proceeding to the three operating suites. He/she indicated the surfaces in the operating suites were cleaned by the nursing staff with the disinfectant wipes so he/she only used vinegar water for the terminal cleaning. He/she also indicated the vinegar water was used to clean all of the sinks, including the scrub sinks.</p> <p>2. The document provided to the housekeeping services by the facility indicated, "B. Sterile Areas Including 3 OR's, ER, and Minor Procedure: Daily: 1. Clean, disinfect, and polish dry all wash basins, surgery tables, stretchers, OR furniture, countertops, hanging light fixtures, soap dispensers, waste dispensers and all other washroom fixtures. ...4. Sweep, wet mop and disinfect all hard surface floor areas." The document did not address specific products to use or step by step instructions of how to proceed through the surgical areas.</p> <p>3. The facility policy "Surgical Services", indicated, "IX. Operating Room Cleaning: 7. All flat surfaces, OR tables and equipment are wiped with a germicide. This includes lights and visibly soiled areas of the room. ...XI. Housekeeping in the operating room: C. Housekeeping will provide terminal</p>			

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	<p>cleaning (see IX.C. above) and all other cleaning as outlined in hospital policy." The policy did not address specific products to use or step by step instructions of how to proceed through the surgical areas.</p> <p>4. At 2:45 PM on 02/13/13, staff member #A1 indicated he/she was not aware of the vinegar water being used for cleaning or the same mop head being used for all of the surgical area. He/she did indicate, however, that the nursing staff wiped all of the surfaces with a germicidal wipe prior to the start of any surgical procedures each day.</p>			

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S000780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure their policy was followed regarding verbal orders in 9 of 16 patient charts reviewed (#N3, N7, N8, N9, N10, N12, N13, N14 and N16).</p> <p>Findings included:</p> <p>1. The facility policy "Verbal and Written Orders", effective December 2010, indicated, "A 'read back' process will be conducted by the individual receiving the order, whereby the individual will read back, to the medical staff member, the frequency and/or all instructions for use in the non-abbreviated format. ...The medical staff member shall verbally confirm that the order is correct. ...The</p>	S000780	S780 Policies and documentation guidelines will be reviewed concerning the documentation of medications given intra operative. The Director of Nursing for the Surgery Center will be responsible for the overseeing of this action. Monitoring of verbal drug orders and their documentation will be monitored and reviewed by the QAPI committee on a quarterly basis until further notice. Policies concerning verbal orders will be reviewed with the staff at the next staff meeting. This reporting will begin with the 2 nd quarter of 2013.	03/21/2013			

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	<p>prescribing practitioner, or another practitioner responsible for the patient's care, must date, time and authenticate the verbal/telephone order within 72 hours of giving the order."</p> <p>2. The medical record for patient #N3 indicated a verbal order at 0935 on 10/31/12, but without any method to determine the read back process and with no date or time with the physician's signature to determine adherence to policy.</p> <p>3. The medical record for patient #N7 indicated a verbal order at 0909 on 11/26/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>4. The medical record for patient #N8 indicated a verbal order at 1145 on 11/30/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>5. The medical record for patient #N9 indicated a verbal order on 11/30/12 (no</p>						

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	<p>time) on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>6. The medical record for patient #N10 indicated four verbal orders at 1315 on 11/07/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>7. The medical record for patient #N12 indicated a verbal order at 1007 on 11/08/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>8. The medical record for patient #N13 indicated a verbal order at 1123 on 11/07/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p>			

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	<p>9. The medical record for patient #N14 indicated a verbal order at 1002 on 11/19/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy.</p> <p>10. The medical record for patient #N16 indicated a verbal order at 1035 on 10/01/12 on the Operative Record, but without any method to determine the read back process and with no date or time with the physician's signature on the bottom of the form to determine adherence to policy. The record also had an order for Tylenol written by the nurse on the Anesthesia Standing Order form, but without indicating it was a verbal/telephone order and from which provider.</p> <p>11. At 3:40 PM on 02/13/13, the medical record findings were reviewed with staff member #A1 who confirmed the lack of the verification process and lack of date, time, and signature with the verbal orders even though the physicians signed the bottom of the Operative Records.</p>						

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure accurate operative reports were written/dictated immediately following surgery for 4 of 16 medical records reviewed (#N1, N3, N8, and N11).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Record Content", effective April 2011, indicated, "Operative reports are dictated for the medical record immediately (within 24 hours) following surgery."</p>	S000888	S888 Policies and dictation guidelines will be reviewed concerning post operative dictation. The Director of Nursing for the Surgery Center will be responsible for the overseeing of this action. Suggested policy changes, if appropriate, will be presented to the Executive Board at the 2 nd quarter 2013 meeting for approval. This information will be communicated to the Medical Staff. Dictations will be audited for timeliness of dictations and this information will be presented to the Executive Board quarterly until further notice	03/21/2013			

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	<p>2. The medical record for patient #N1, who had a procedure on 01/24/12 and was transferred to the hospital afterwards, indicated an operative report that indicated the patient was discharged home in satisfactory condition. The report was dictated on 01/24/12, but not signed by the physician until 02/01/12 allowing time for an addendum regarding the transfer.</p> <p>3. The medical record for patient #N3, who had a procedure on 10/31/12, indicated the operative report was not dictated until 11/07/12.</p> <p>4. The medical record for patient #N8, who had a procedure on 11/30/12, indicated the operative report was not dictated until 12/05/12.</p> <p>5. The medical record for patient #N11, who had a procedure on 10/30/12, indicated the operative report was not dictated until 11/06/12.</p> <p>6. At 3:40 PM on 02/13/13, the medical record findings were reviewed with staff member #A1 who confirmed the delay with the dictation of the operative reports and the inaccuracy of the report for patient #N1.</p>						

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S001024	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>Based on observation, interview, and policy review, the facility failed to ensure syringes/containers of medication were labeled according to policy and standard of practice.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area on 02/13/13 with staff member #A1, the following observations were made in stations of the block area:</p> <p>A. Seven one milliliter (ml.) syringes of a clear solution, labeled "Xylocaine 1% 2/13", in a plastic container on a counter in the first station.</p> <p>B. Seven one milliliter (ml.) syringes of a clear solution, labeled "Xylocaine 1% 2/13", in a plastic container on a counter</p>	S001024	<p><u>S1024</u> Policies concerning medication labeling will be reviewed with both medical and nursing staff. An amendment will be made to the policy to include the initialing who prepares the medication when labeling. Safety rounds concerning proper medication labeling will be done periodically and findings reported to the QAPI committee for review.</p>	03/21/2013			

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	<p>in the second station. Also on the counter was a plastic cup with a lid, containing a clear solution, which was labeled "Xylocaine 1% 2/13/13".</p> <p>2. At 10:40 AM on 02/13/13, staff member #A1 indicated the anesthesiologist probably poured the Xylocaine into the cup from the vial and filled the syringes that way instead of withdrawing the solution from the vial with each syringe.</p> <p>3. The facility policy "Medication Protocol in the Perioperative Setting: Labeling/Dispensing", last revised March 2011, indicated, "Label container medication is poured into as well as syringe it may be placed into. Label name, strength, and dosage on all containers, syringes, etc."</p> <p>4. Standard of practice for medications that are pre-drawn is to label the syringes/containers with time of draw, initials of the person drawing, medication name, strength and expiration date or time.</p>			

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S001146	<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, interview, and policy review, the facility failed to ensure patient safety by monitoring the temperature of the fluids and supplies in the warming cabinet in the Procedure Room.</p> <p>Findings included:</p> <p>1. During the tour of the Procedure Room at 2:30 PM on 02/13/13, accompanied by staff members #A4 and A9, a Blickman warming cabinet was observed full of blankets and a package of Povidone iodine scrub sponges and a 1000 milliliter bottle of 0.9% NaCl irrigation fluid. The package of the sponges and the irrigation solution were too warm to hold. The sides of the bottle of solution were bulging and the label had a written expiration date of 02/20/13. No thermometer was in or on the cabinet, making it unable to determine the temperature, but the dial at the bottom was turned to 9.5 with 10 being the highest setting. A written note on the cabinet indicated fluids could be in the warmer for 14 days.</p> <p>2. At 2:35 PM on 02/13/13, both staff members</p>	S001146	<p>S1146 The policy concerning fluid and supply warming will be reviewed and information concerning patient safety issues will be addressed. We are in the process of purchasing a separate fluid warmer. Upon receipt will follow the manufacturers' recommendations for both the warmer and the fluid warming guidelines concerning monitoring the warming process. This monitoring will be added to the QAPI concerning patient safety issues. The Director of Nursing will be responsible for the oversight of this action. Updated policies and guidelines will be presented to the Executive Board at the 2 nd quarter meeting of 2013.</p>	03/21/2013

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	<p>#A4 and A9 indicated they thought there was a thermometer in the cabinet, but one could not be found. They indicated the temperature was not monitored and they were unsure of what the temperature should be.</p> <p>3. At 3:15 PM on 02/13/13, staff member #A1 indicated the facility did not have policies regarding the warmers, did not have recommendations of acceptable temperatures from the fluid manufacturer, and did not know what temperatures were recommended by the cabinet manufacturer.</p>				