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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153039 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/10/2015 |
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| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOWARD SPECIALTY HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 829 N DIXON RD KOKOMO, IN 46901 |
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| S 000 Bldg. 00 | This visit was for a State hospital licensure survey. Dates: 2/9/2015 through 2/10/2015 Facility Number: 003868 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 03/13/15 | S 000 | | |
| S 406 Bldg. 00 | 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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 | | | |

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>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 hospital failed to ensure 6 services are part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Community Howard Specialty Hospital 2014 Performance Improvement Plan indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Community Howard Specialty Hospital 2014 Performance Improvement Reporting Grid did not identify: Dietetic Services; Bioengineering Services; Biohazardous Waste Hauler; Laundry/Linen Services; | S 406 | <p>The comprehensive Quality Assessment and Improvement Plan was revised to include the department-specific quality indicators, which are assessed on a monthly basis. Department leaders are responsible to develop monthly action plans for indicators that are not within acceptable thresholds. The actions within the plans are now documented, and the outcome and effectiveness of the actions are demonstrated, through a Performance Improvement Grid. The Performance Improvement Grid is a fluid document that allows for indicators to be identified, developed, and implemented through a systematic and measurable process, thus allowing indicators to be added or deleted depending upon the needs of the organization. The Quality Assessment and Improvement Plan is now reviewed on a monthly basis at the Medical Executive Committee and Leadership meetings. The Administrator is responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | 02/18/2015 |

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| S 418 Bldg. 00 | <p>Maintenance Services; and Housekeeping Services.</p> <p>3. At 1:30 PM on 2/9/2014, staff member #18 (Interim Administrator/QA) confirmed the 6 services were not part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p> <p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on documentation review and staff interview, the hospital failed to document action plans for improving the quality indicators</p> | S 418 | The comprehensive Quality Assessment and Improvement Plan was revised to include the department-specific quality indicators, which are assessed on | 02/18/2015 |

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| | <p>that did not meet their performance goals.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Community Howard Specialty Hospital 2014 Performance Improvement Plan indicated the Performance Improvement (PI) Committee utilizes the Performance Improvement Grid review collection of data to process improvement, to identify, develop, implement, and measure the improvement. The PI Committee systematic process will be utilized to analyze collected data in order to determine actions to improve the performance of processes. The plan indicated the Medical Executive Committee shall be responsible for an ongoing monitoring and evaluating of quality indicators. 2. Community Howard Specialty Hospital Performance Improvement Reporting Grid was reviewed for 2014. Approximately | | <p>a monthly basis. Department leaders are responsible to develop monthly action plans for indicators that are not within acceptable thresholds. The actions within the plans are now documented, and the outcome and effectiveness of the actions are demonstrated, through a Performance Improvement Grid. The Performance Improvement Grid is a fluid document that allows for indicators to be identified, developed, and implemented through a systematic and measurable process, thus allowing indicators to be added or deleted depending upon the needs of the organization. The Quality Assessment and Improvement Plan is now reviewed on a monthly basis at the Medical Executive Committee and Leadership meetings. The Administrator is responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | | |

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| | <p>35% of the hospital's selected quality indicators did not meet their performance goals. The hospital did not provide documented evidence of action plans for improving quality indicators that did not meet their threshold.</p> <p>3. December 23, 2014 Leadership Meeting indicated percent at goal for Operational Outcome indicators were 47.4%. The documentation provided did not evidence action plans for the other 52.6% quality indicators that did not meet their performance goals.</p> <p>4. The Community Howard Specialty Hospital Medical Executive Committee Meeting minutes were reviewed for 2014. The minutes that were provided documented discussion of quality improvement only in the 1st and 2nd quarter: 2/19/14, 3/19/14, and 4/16/14. Quality Improvement activities were not documented in the 3rd and 4th quarter of 2014.</p> | | | |

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| S 554 Bldg. 00 | <p>There was no documented action plans discussed on quality indicators that did not meet their performance goals as evidenced in the Performance Improvement Reporting Grid.</p> <p>5. At 2:00 PM on 2/9/2015, staff member #18 (Interim Administrator/QA) confirmed the hospital did not document action plans for performance goals that did not meet their threshold.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, manufacturer's directions, policy and procedure review, and interview, the facility failed to ensure a safe environment for patients and ensure accurate testing results by checking supplies to prevent outdated usage.</p> | S 554 | Immediately following the survey, education was provided and the hospital policy was reviewed with all nursing staff regarding checking expiration dates on the control solution for the Accu-Chek glucose monitor. The staff was instructed on required process, | 03/01/2015 |

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| | <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the inpatient unit at 2:50 PM on 02/09/15, accompanied by staff member #4, the Nurse Manager, two sets of control solution for the Accu-Chek glucose monitor were observed with labels indicating the controls were opened on 10/10/14 and should be discarded on 01/10/15. 2. Manufacturer's directions indicated the control solutions were effective for 90 days after opening, then should be discarded. 3. The facility policy "Accu-Chek Advantage: Glucose Blood Monitoring System", last reviewed 05/2012, indicated, "Operating Guidelines: ...3. Each bottle of control solution is stable for 90 days after opening. Control solution bottles should be dated when opened. Discard all unused solutions 90 days after opening." 4. During the tour at 2:50 PM on 02/09/15, staff member #4 indicated he/she thought the control solutions could be used until the manufacturer's labeled expiration date . 5. At 3:10 PM on 02/09/15, staff | | <p>and a return demonstration was observed to assure that the manufacturer's directions for the control solutions are followed. Said education specifically reinforced the dating of the control solution when opened and the disposal of the control solutions 90 days after opening. A quality improvement indicator has been added to the nursing section of the Performance Improvement Grid relating to monitor adherence to policy for dating the Accu-Chek control solution according to manufacturer's directions. The Nurse Manager is responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | |

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| S 570 Bldg. 00 | <p>member #14, a nurse on the inpatient unit, indicated he/she thought the control solutions could be used until the manufacturer's labeled expiration date .</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on facility document review and interview, the facility failed to ensure the infection control committee was comprised of the required members and failed to ensure the infection control</p> | S 570 | The Infection Prevention and Control Committee that provides for Community Howard Regional Health (parent, acute care hospital) of has been expanded to include administrative and nursing | 02/18/2015 |

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| | <p>committee met quarterly to ensure all aspects of the Infection Control Program were reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Medical Staff Bylaws and Rules and Regulations, effective November 21, 2012, indicated, "Infection Control: a. The Medical Staff Executive Committee shall serve as the initial reviewing body for reports and information from the Infection Control Subcommittee. The subcommittee shall meet at least every other month and shall report every other month to the Medical Staff Executive Committee. b. The Infection Control Subcommittee shall consist of a pathologist, the Hospital Infection Control Practitioner, the Vice President of Nursing (or designate), and the President (or designate). This subcommittee shall report on surveillance of hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities." Review of the Medical Executive Committee Meeting minutes for the last quarter of 2014 failed to indicate any | | <p>representatives of Community Howard Specialty Hospital (CHSH). The Committee will carry a standing agenda item for discussion of CHSH infection prevention and control topics. The Infection Prevention and Control Committee representatives from CHSH will serve as the sub-committee responsible for reporting to the CHSH Medical Staff Executive Committee on an at least bi-monthly basis. The Administrator and Infection Preventionist are responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | |

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| | <p>mention or discussion of infection control issues.</p> <p>3. Review of the Leadership Team Meeting minutes for the last quarter of 2014 indicated the Performance Improvement Reporting Grids, which included some infection control statistics, were reviewed, but there was no documentation of discussion or plans of correction. The committee members did not include a pathologist or any other physician.</p> <p>4. At 1:30 PM on 02/09/15, staff member #12, the Infection Preventionist, indicated he/she had just assumed this role in July of 2014 and was working towards his/her certification. He/she indicated the infection control committee was actually the Medical Executive Committee which met quarterly and discussed all infection control issues.</p> <p>5. At 12:45 PM on 02/10/15, staff member #12 confirmed there was no actual subcommittee as specified in the bylaws and rules and regs. He/she indicated the infection control dashboards were discussed at the leadership committee meetings, but confirmed the membership did not include any physicians. He/she also confirmed there was no documentation of discussion of</p> | | | |

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| S 602 Bldg. 00 | <p>infection control issues in the minutes of the Medical Executive Committee.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vi)</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>(vi) An isolation system. Based on policy and procedure review, observation, and interview, the facility failed to ensure patients and staff were protected from cross contamination by ensuring isolation precautions were followed.</p> <p>Findings included:</p> <p>1. The facility policy "Transmission</p> | S 602 | Immediately following the survey, a review of contact precautions was provided for all nursing staff. Return acknowledgement of understanding was provided. A Quality Improvement Indicator has been added to the infection prevention & control section of the Performance Improvement Grid, addressing contact precautions. Staff found to be non-compliant with isolation | 02/11/2015 |

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| | <p>Based Precautions", last reviewed 08/15/12, indicated, "D. Contact Precautions: Contact Precautions are designed to reduce the risk of transmission of microorganisms by direct or indirect contact. Specifications for Contact Precautions: ...Remove gloves before leaving the patient's environment and wash hands immediately, use of alcohol based waterless hand cleaner is acceptable if hands are not soiled. Handwashing only is acceptable if hands are soiled or if patient has C. difficile. Be sure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room upon leaving. Wear a gown when entering the patient's room if you anticipate contact with the patient's body fluids. Remove the gown before leaving the patient's room and place in soiled linen bag (or trash if gown is disposable). Do not re-use gowns. After gown removal, be sure that clothing does not contact any environmental surfaces. Wash hands before leaving the room and do not touch any surfaces."</p> <p>2. During the tour of the inpatient unit at 3:15 PM on 02/09/15, accompanied by staff member #4, the Nurse Manager, signage on the outside of room 206 indicated contact isolation was in place and a gown and gloves should be worn</p> | | <p>precautions will be counseled individually at the time of infraction. Re-education or progressive discipline will ensue depending on determined causal factor(s) for non-compliance. The Nurse Manager and Infection Preventionist are responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | |

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| S 608 Bldg. 00 | <p>upon entering the room. "Wash hands with soap and water" was written on the isolation sign. While standing outside the room, the surveyor observed a tech enter the room wearing gloves and stripping the linens from the bed and removing the trash. The tech tied up the trash bag, brought it to the doorway, removed his/her gloves, used the waterless foam hand cleaner, then proceeded down the hall with the trash.</p> <p>3. At 3:20 PM on 02/09/15, the tech, staff member #15, was questioned regarding the isolation room and whether he/she had received directions different from the signage. He/she indicated he/she had not received any other instructions and did not wear a gown because the patient was not in the room at the time.</p> <p>4. At 3:25 PM on 02/09/15, staff member #4 confirmed the tech did not follow proper isolation precautions.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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</p> | | | |

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| | <p>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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on documentation review and observation, the facility failed to ensure kitchen staff wash their hands between removing and changing single-use gloves as per policy and 410 IAC 7-24-129; Retail Food Establishment Sanitation Requirements.</p> <p>Findings Included:</p> <p>1. Community Howard Specialty Hospital policy Dietary-07 (last reviewed 11/6/2014) indicated handwashing is necessary before beginning work; before the preparation and serving of food; after restroom visits; after handling of money, clothing, shoes, body skin, or any other object that may be a source of contamination.</p> | S 608 | <p>Immediately following the survey, the hand washing policies and procedures were reviewed with all dietary staff. Hand washing observation of dietary staff has been added to the hospital-wide infection control surveillance and reporting. Staff found to be non-compliant with hand washign requirements will be counseled individually at the time of infraction. Re-education or progressive discipline will ensue depending on determined causal factor(s) for non-compliance. The Director of Food & Nutrition Services is responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | 02/10/2015 | | | |

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| | <p>2. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands indicated food employees shall clean their hands and exposed portions of their arms immediately: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After coughing, sneezing, or using a handkerchief or disposable tissue; After handling soiled surfaces, equipment, or utensils; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands.</p> <p>3. At 10:00 AM on 2/9/2015, three kitchen staff members were observed changing their gloves without washing their hands prior to putting on the single-use gloves.</p> | | | |
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| S 952 Bldg. 00 | <p>The kitchen staff members' hands were observed handling soiled items and wiping counters before the gloves were put on.</p> <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 and procedure review, medical record review, and interview, the facility failed to ensure physician orders and policy were followed regarding blood transfusions for 5 of 5 patients receiving blood transfusions (#N1, N2, N3, N4, and N5).</p> <p>Findings included:</p> <p>1. The facility policy "Blood Product Administration: Packed Red Cells, Frozen Plasma", last reviewed 08/15/12,</p> | S 952 | Orders for blood transfusion and the administration of Lasix have been updated within the Cerner EMR, consistent with the current policy. The blood transfusion policy was reviewed with nursing staff, including re-training regarding the execution of blood transfusions and appropriate documentation thereof. A Quality Improvement initiative for the monitoring of blood transfusions has been implemented, wherein execution of every blood transfusion is observed and assessed in "real time". The Performance Improvement Grid | 02/11/2015 |

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| | <p>indicated, "1. Physician order for blood products a. Orders for blood products are written on physician's order sheet. b. Physicians are responsible for indication, which must be ordered into Meditech in order to complete the order. Only physicians may originate the indication. ...20 RN [registered nurse] must stay at bedside until 15 minutes check is completed and documents vital signs on the Blood Product Transfusion form. 21. Vital signs are to be monitored closely and recorded for each unit of blood administered. Immediately (no more than 30 minutes) prior to the infusion. Following first 15- 25 minutes of administration . Following completion of each unit (within 15 minutes)."</p> <p>2. The medical record for patient #N1 indicated a physician order from 10/21/14 which indicated, "Transfuse 2 units. Additional instructions: Give 20 mg. [milligrams] Lasix PO [by mouth] before transfusion begins, Request to give product: Today." The medical record lacked documentation that the Lasix was given.</p> <p>3. The medical record for patient #N2 indicated a physician order from 12/23/14 which indicated, "Transfuse 2 units. Additional instructions: Give 20 mg. Lasix PO before transfusion begins,</p> | | <p>now includes an indicator for blood transfusing according to policy. The Nurse Manager is responsible for these corrective actions and efforts to ensure deficiency does not recur.</p> | | |

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| | <p>Request to give product: Today." The medical record lacked documentation that the Lasix was given.</p> <p>4. The medical record for patient #N3 indicated a physician order from 10/15/14 which indicated, "Transfuse 2 units. Additional instructions: Give 20 mg. Lasix PO before transfusion begins, Request to give product: Today." The medical record lacked documentation that the Lasix was given. The record indicated the first unit was started at 1915 hours on 10/15/14, but lacked documentation of any vital signs within 15- 25 minutes of the start of the transfusion. The second unit was started at 2207 hours, but again there was no documentation of vital signs within 15- 25 minutes of the start of the transfusion.</p> <p>5. The medical record for patient #N4 indicated a physician order from 01/01/15 which indicated, "Transfuse 2 units. Additional instructions: Give 20 mg. Lasix PO before transfusion begins, Request to give product: Today." The medical record lacked documentation that the Lasix was given. The record indicated the second unit was started at 0155 hours on 01/02/15, but lacked documentation of any vital signs within 15- 25 minutes of the start of the transfusion.</p> | | | |

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| S 186 Bldg. 00 | <p>6. The medical record for patient #N5 indicated a physician order from 01/09/15 which indicated, "Transfuse 2 units. Additional instructions: Give 20 mg. Lasix PO before transfusion begins, Request to give product: Today." The medical record lacked documentation that the Lasix was given.</p> <p>7. At 11:45 AM on 02/10/15, staff member 34, the Nurse Manager who navigated the EMR (Electronic Medical Records), indicated the oral Lasix order must have been something that was programmed in with the order because that was not the route or the time that Lasix was usually given with blood transfusions and did not carry over to the Medication Administration Record for nurses to administer the medication. However, he/she confirmed it was attached to the order and had been noticed by a physician. He/she also confirmed the records lacked the appropriate vital sign documentation.</p> <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:</p> | | | |
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| | <p>(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 documentation review and staff interview, the facility failed to ensure fire drills were conducted monthly one per shift per quarter for the four quarters of 2014 as per hospital policies and procedures.</p> <p>Findings included:</p> <p>1. Community Howard Specialty Hospital Fire Drill Policy (last reviewed 11/6/2014) indicated fire drills will be held monthly. Each shift of personnel will have a fire drill at least quarterly in each separate patient-care building.</p> | S 186 | The Director of Risk & Safety Management has provided a schedule of Fire Drills to the Administrator, including quarterly drills to occur on each 12-hour shift. The Fire Drill policy has been reviewed and modified to reflect the schedule. On January 19, 2015 a fire drill was held for the first shift and on March 4, 2015 a fire drill was held for the second shift. The Director of Risk & Safety Management is responsible for these corrective actions and efforts to ensure deficiency does not recur. | 03/03/2015 | | | |

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| | <p>2. The fire drill documentation that was provided noted the hospital had four completed fire drills for 2014 that were held on first shift only: 3/24/2014, 6/19/2014, 8/20/2014, and 11/20/2014. Therefore, the hospital lacked 8 fire drills for 2014 and lacked at least one per shift per quarter as evidenced by hospital's policy and procedures.</p> <p>3. At 10:45 AM on 2/10/2015, staff member #5 (Risk Manager/Safety) indicated the hospital conducts two 12-hour shifts. The staff member confirmed the documentation does not confirm a fire drill was conducted monthly and at least one per shift per quarter.</p> | | | |