

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NOBLE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SAWYER RD KENDALLVILLE, IN 46755
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S 0000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 002434</p> <p>Survey Date: 02-15/17-2016</p> <p>QA: cjl 03/16/16</p> <p>IDR Committe held on 04-14-16, Tag S1118 modified & Tag S1186 deleted. JL</p>	S 0000	<p>The following constitutes Parkview Noble Hospital's response to the findings of the Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies. The deficiencies cited within this survey report were reviewed via in- person meetings by senior leadership including the President, VP of Patient Services, Department Managers, Quality, Infection Control, and Safety. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report.</p>	
S 0556 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review, observation and interview, the hospital failed to</p>	S 0556	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken</p>	02/17/2016

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>ensure an active and effective infection control program related to the renovation of flooring in the surgical department.</p> <p>Findings Include:</p> <p>1. Review of the infection prevention policy: Construction and Construction Risk Assessments, no policy number, last approved 9/2014, indicated:</p> <p>A. On page 5 under item 9:...risk criteria will address the impact that demolition, renovation, or new construction activities have on air quality requirements, infection prevention and control...10. Functions and responsibilities of the IPC (infection prevention control) department and EOC (environment of care) Committee:...d. Oversee all infection control aspects of construction activities. e. Establish site-specific infection control protocols for specialized areas...h. Ensure compliance with technical standards, contract provisions, and regulations. i. Daily monitoring of worker adherence to infection control guidelines in and around the work site.</p> <p>B. On page 7, in item 13., Internal Demolition, Construction, Renovations, and Repairs...c. Removal of flooring and carpeting.</p> <p>2. Review of the ICRA (infection control</p>		<p>and the date of correction. Corrected during survey: An ICRA work order is now generated for projects on a daily basis. The primary facilities staff member has been oriented to do a walk round, complete the ICRA observation assessment and subsequent documentation. Any issues with the assessment are addressed at that time. 2. How are you going to prevent the deficiency from recurring in the future? ICRA in service training for all facilities staff at orientation and annually thereafter. This requirement will be tracked via the EOC/LS tool. 3. Who is going to be responsible for numbers 1 and 2 above? The Facilities Manager is ultimately responsible for the corrective action and ongoing compliance.</p>	

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	<p>construction risk assessment) indicated:</p> <p>A. The flooring project in the surgery department was a Type C, "Work that generates a moderate-to-high-level of dust or requires demolition or removal of any fixed building components or assemblies" and "Includes, but is not limited to...Removal of floor coverings, ceiling tiles and casework...".</p> <p>B. On page 4, it is noted that the "Precaution Class" for this project was III/IV.</p> <p>C. On page 5, Class III indicated staff needed to "Adhere to all the above and:</p> <ol style="list-style-type: none"> 1. Consult Infection Control before work begins. 2. Erect an impermeable dust barrier around worksite and ensure walls, doors and penetrations are sealed. 3. Disable/isolate HVAC (heating, ventilating, and air conditioning) system in work area. 4. Maintain negative pressure in worksite by direct venting to outside or by using HEPA (high-efficiency particulate arrestance) equipped air filtration units. 5. Construction workers must wear protective clothing...". <p>3. At 1:15 PM on 2/15/16, while on tour of the surgery department in the company of staff member #59, the surgery manager, it was observed that flooring was being removed and replaced in the hallway outside the surgery suites.</p>			

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S 0744 Bldg. 00	<p>4. At 1:45 P on 2/16/16, interview with staff members #56, the support services manager, and #62, the infection preventionist, confirmed that:</p> <p>A. Various staff are monitoring the construction project that was approved in October 2015 for starting in November 2015.</p> <p>B. This observation between staff was a daily occurrence.</p> <p>C. There was no documentation to support daily observations to determine if all of the Class III requirements, as listed in 2. above, were being implemented.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and interview, the facility failed to ensure that transfer forms were complete for 3 of 3 transfer patients, patients #14, 15 and 16.</p> <p>Findings Include: 1. Review of the policy Discharge Planning, no policy number, last approved 4/2014, indicated on page 4 under Patient Transfer to Other Facilities, that this section related only to long term</p>	S 0744	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Staff were educated on the transfer documentation requirements via email, memo, discussion at huddle, and unit meeting. A sample of a completed transfer form has been posted for visual reference. Medical Records will flag record for physician signature within 30-days of discharge. Physician education via	04/01/2016

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	<p>care facilities, and on page 5, only to ED (emergency department) transfers.</p> <p>2. Review of the policy Admission, Discharge, Transfer, no policy number, last approved 5/15/2014, indicated on page 2 under "III. Transfer Criteria" that:</p> <p>A. Some instances may necessitate the transfer of the patient to other clinical settings as determined by the patient status and deemed appropriate by the physician. B. When patient need necessitates transfer to another unit, a physician order is needed with the physician writing the preference for area of transfer in the order. C. Such transfers will be for more intensive or specialty care based on the patient's medical need.</p> <p>3. Review of medical records indicated:</p> <p>A. Pt. #14 had a Certificate of Transfer form (form #766) that lacked completion on page two of the Accepting Physician and time of acceptance, the accepting facility representative name and time of contact, and no check in the box for the patient's acknowledgement of risks and benefits and the consent for transfer.</p> <p>B. Pt. #15 had no transfer form (form #766) completed, but did have a physician Certification Statement of Medicare/Medicaid Transportation Services need that was not authenticated</p>		<p>memo, email, and at MEC meeting 2. How are you going to prevent the deficiency from recurring in the future? Audit 100% of transfers, up to 10/month, for 3 consecutive months Audit results to be reported weekly at Leadership Huddle and monthly at physician Clinical and MEC committees Quarterly review of transfer documentation to be reported to Clinical Committee for oversight. 3. Who is going to be responsible for numbers 1 and 2 above? The VP of Patient Services is ultimately responsible for the corrective action and ongoing compliance.</p>				

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	<p>by the physician for approval of the transport.</p> <p>C. Pt. #16 had a Certificate of Transfer form (form #766) that lacked completion on page one of the risks and benefits of transfer having been explained to the patient and on page 2, lacked documentation of who report was called to at the accepting facility and their name, and had no check in the box for the patient's acknowledgement of risks and benefits and the consent for transfer.</p> <p>4. At 11:30 AM on 2/17/16, interview with staff member #63, the house supervisor, confirmed that the transfer form #766 for patients #14 and #16 were incomplete as per expectations of the facility.</p> <p>5. At 12:30 PM on 2/17/16, interview with staff member #52, the vice president of patient services, confirmed that:</p> <p>A. Pt. #15 was sent to another facility for an interventional radiology procedure and then returned back to this facility so that it wasn't thought to be a transfer, thus no form #766 was completed.</p> <p>B. The physician did fail to authenticate the order for transport for patient #15.</p> <p>C. The current policies, listed in 1. and 2. above, are lacking in clear communication to nursing staff on the unit how to proceed with transfers to a</p>						

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S 0912 Bldg. 00	<p>higher level of care.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the nursing executive failed to</p>	S 0912	1. How are you going to correct the deficiency? If already corrected, include the steps taken	04/01/2016

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	<p>ensure that nursing personnel performed pediatric admission assessments per standards of practice for 1 of 2 pediatric patients under 2 years of age, patient #17.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Review of pediatric chart #17 indicated this was a 15 month old admitted 2/4/15 with fever. The pediatric assessment lacked a head circumference measurement on the Peds Vital Signs area of the medical record. 2. At 12:00 PM on 2/17/16, interview with staff member #61, the inpatient unit manager, confirmed that no head circumference documentation was done for patient #17 when the pediatric admission assessment was completed. 3. At 12:15 PM on 2/17/16, interview with staff member #64, the facility educator, confirmed that a head circumference was to be measured on each child admitted to the facility who was under 2 years of age. 4. At 12:30 PM on 2/17/16, interview with the vice president of patient services, staff member #52, confirmed that the facility had no policy stating pediatric patients under 2 years of age should have a head circumference measurement, but that it is a standard of 		<p>and the date of correction. The policy "Standards of Care: Pediatrics" from the nursing clinical Practice Manual addresses measuring head circumference is current (last reviewed 04/2014 and is available on line).We believe this was provided to the surveyor while on-site. Pediatric assessment flow was wrenched into the nurses EPIC electronic medical record (EMR) for documentation prompts upon admission. This flow includes documentation of head circumference for pediatric age up to 2-years. Staff were educated via email on how to include this flow sheet in their electronic documentation. Nurse leads review all pediatric admissions at daily shift change huddle Nursing staff review and sign off on the policy"Standards of Care: Pediatrics" 04/01/2016 - Nursing all-staff education regarding EMR documentation requirements and associated policy was distributed via: email,discussion at huddle, and posted to the huddle board for visual reference. Education at MedSurg / CCU unit meeting.</p> <ol style="list-style-type: none"> 2. How are you going to prevent the deficiency from recurring in the future? Audit 100% of pediatric admissions, up to 10/month, for three consecutive months Audit results to be reported weekly at Leadership Huddle and monthly at physician Clinical and MEC committees 	

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S 1118 Bldg. 00	<p>practice for this measurement to be done.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on document review & observation the hospital created a condition which could result in a hazard to patients, public or employees in 1 instance.</p> <p>Findings include;</p> <p>1. Review of hospital policy title: Compressed Gas, Last Approval Date 02/2014, indicated "compressed gas cylinders must be secured by chains or to an approved type and design of cart specifically designed to resist movement".</p>	S 1118	<p>Oversight of pediatric admissions and assessment by House Supervisors 3. Who is going to be responsible for numbers 1 and 2 above? The Inpatient Manager is ultimately responsible for the corrective action and ongoing compliance.</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Key stakeholders who are in this storage room and/or who handle tanks were educated. This includes: Cardio Pulmonary Services, SCORE(Supply Chain), and Facilities Score receives the tanks. Facilities changes out the tanks. A sign was posted as a visual reminder to secure tank storage. 2. How are you going to prevent the deficiency from recurring in the future? We will assess compliance via observation during routine</p>	04/01/2016	

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S 1125 Bldg. 00	<p>2. On 02-15-16 at 2:10 PM in the presence of employees, #A2, President, #A6, Safety and #A7, Manager Support Services, it was observed in the gas storage area of the main hospital that there were 2 large nitrogen compressed gas cylinders standing upright on the floor unsecured by chain or holder.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on document review and interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 5 of 6 systems of</p>	S 1125	<p>Environment of Care (EOC) Rounding. Results of observations will be reported to monthly Safety Committee for trending and follow up. 3. Who is going to be responsible for numbers 1 and 2 above? The Facilities Manager is ultimately responsible for the corrective action and ongoing compliance.</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 1st 30-days: Requested PM protocols from Manufacturers. 2nd 30-days:</p>	04/01/2016

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S 1172 Bldg. 00	<p>equipment.</p> <p>Findings include:</p> <p>1. On 02-15-2016 at 12:30 pm, employees #A6, Safety, and #A7, Manager Support Services, were requested to provide documentation of the operational and maintenance control records for the air conditioning system, air handler, air (vacuum) pump, boiler, elevator, emergency generator, and fire alarm system having been analyzed at least triennially.</p> <p>2. Interview of employee #A7 on 02-16-2016 at 12:30 pm, confirmed there was no documentation for the air conditioning system, air handler, air (vacuum) pump, boiler, elevator, and fire alarm system, and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p>		<p>We will begin to evaluate our process to align with the protocols. We will add the protocol PM review to the Life Safety (LS) and Environment of Care (EOC) Tracking Tool and organization Grid for the air conditioning system, air handler, air(vacuum pump), boiler, elevator, emergency generator, and fire alarm systems. On-going: We will review the PM protocol for each system asit comes up for regularly scheduled PM. 2. How are you going to prevent the deficiency from recurring in the future? We will review completion for LS and EOC items at monthly Safety Committee meeting A summary of the Safety Committee minutes is provided to Board Quality for Leadership Oversight. 3. Who is going to be responsible for numbers 1 and 2 above? The Facilities Manager is ultimately responsible for the corrective action and ongoing compliance.</p>				

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	<p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on document review, observation and interview, the facility failed to ensure that housekeeping and nursing staff were cleaning and disinfecting surfaces and equipment per policy and standards of practice.</p> <p>Findings Include: 1. Review of the Infection Prevention policy, no policy number, last approved 12/2014, indicated A. On page 4, Concept 256N was to be used for: Environmental cleaning of "touch" surfaces, stethoscopes, tabletops, countertops, bedpans, blood pressure cuffs, wheel chairs, carts, IV (intravenous) poles, computer keyboards, and similar medical equipment- -Environmental cleaning of "touch" surfaces in Newborn Nursery...isollettes, radiant warming beds, other infant contact surfaces. B. On page 9, NRFC (no rinse floor cleaner) was to be used on "Floors".</p> <p>2. Review of the Environmental Services</p>	S 1172	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. "Floor cleaner in use was corrected during survey and Concept 256 was put into use. Process and Infection Control Policy for Cleaning and Disinfection was updated to use Concept 256 on the floors. " Infection Control is working with Supply Chain to have one consolidated cleaning product list for PH System. Terminal Cleaning Policy - Update cleaning frequency to weekly for rooms not in use The expired hand sanitizer was replaced with new during survey. ED Staff will include cleaning the monitors as part of the room turnover. OB Staff will include cleaning the drawers in the infant warmer as part of the room turnover. Staff was educated via email, in-staff meetings, and unit huddles 2. How are you going to prevent the deficiency from recurring in the future? Cleanliness and review of the unit's cleaning chemicals are monitored by the EOC Rounding</p>	04/01/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>policy General Cleaning, no policy number, last approved 5/15/2014, indicated on page two that in item 9., the "7-step" procedure included "f. Sanitize floors - wet mop", and on page 5, in the "Sanitize the floor" section, it indicated that "Waste Not floor cleaner" was to be used.</p> <p>3. At 2:05 PM on 2/15/16, while on tour of the endoscopy area, interview with staff member N6, the housekeeper, confirmed that NRFC was being used to mop floors.</p> <p>4. At 3:30 PM on 2/15/16, interview with staff member #56, the manager of support services, confirmed that: A. The NRFC was not an EPA (environmental protection agency), hospital grade product and was not to be used to sanitize floors daily as it has no disinfectant properties. B. The Wayne Concept 256N product was to be used to mop floors in the facility.</p> <p>5. At 1:45 PM on 2/16/16, interview with the infection preventionist, staff member #62, confirmed that; A. The Infection Prevention policy, listed in 1. above, was incorrect as the floor is considered a "surface" and should be cleaned with the 256N product.</p>		<p>Team. Results and trends of EOC rounding and any follow up or actions are reported out to the Safety Committee. 3. Who is going to be responsible for numbers 1 and 2 above? The Vice President of Patient Care is ultimately responsible for the corrective action and ongoing compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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	<p>B. The General Cleaning policy, listed in 2. above, lists a "Waste Not" product that hasn't been used for years, but the policy was never changed to the current/correct product.</p> <p>C. Current policies are not in compliance with practices that are expected with housekeeping staff in floor cleaning.</p> <p>6. Review of the policy Environmental Cleaning in the Perioperative Setting, no policy number, last approved 2/2014, indicated on page 3 that in D., Terminal Cleaning, number 2. reads: Unused rooms should be cleaned once during each 24-hour period during the regularly scheduled workweek.</p> <p>7. Review of the policy Terminal Surgery Cleaning, no policy number, last approved 5/15/14, indicated on page 2, under Procedure, in item 7., h., "Ventilation faceplates" are listed as surfaces to be cleaned.</p> <p>8. At 1:30 PM on 2/15/16, while on tour of the surgery area in the company of staff member #59, the surgery manager, it was observed that there was an accumulation of dust on the wall vent/faceplate in surgery room #3.</p> <p>9. Staff member #59 confirmed that dust</p>			

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	<p>was present on the faceplate and even though room #3 was not used often, it was still to be cleaned routinely, per 24 hours, as per policy.</p> <p>10. At 1:35 PM on 2/15/16, while on tour of the procedure room in the surgery area, in the company of staff member #59, it was observed that two of the Eco Lab wall mounted hadn sanitizer containers had expired, one 4/15 and one 8/15.</p> <p>11. At 1:40 PM on 2/15/16, interview with staff member #59 confirmed that the hand sanitizers had expired and that it was unknown by staff that the hand sanitizers had expiration dates.</p> <p>12. At 1:45 PM on 2/15/16, while on tour of the central sterile department in the company of staff member #59, it was observed that the hand sanitizer had expired 10/15.</p> <p>13. At 1:45 PM on 2/15/16, staff member #59 confirmed that the hand sanitizer had expired 10/15.</p> <p>14. At 2:40 PM on 2/15/16, while on tour of the ED (emergency department) in the company of staff member #52, the vice president of patient services, it was observed that there was an accumulation</p>			

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	<p>of dust on the window ledge surrounding the nursing station, and on the base of two vital signs monitors on wheels.</p> <p>15. At 2:40 PM on 2/15/16, interview with staff member #52 confirmed that there was dust present as listed in 14. above and that housekeeping is responsible for the window ledge and that patient care techs are to clean the vital signs monitors after each patient use.</p> <p>16. At 2:20 PM on 2/16/16, while on tour of the FBC (family birthing center) in the company of staff member #65, the FBC manager, it was observed that the infant warmer/isollette in room 244 had dirt/debris in the drawer of supplies.</p> <p>17. At 2:30 PM on 2/16/16, while on tour of the FBC in the company of staff member #65, the FBC manager, it was observed that the infant warmer/isollette in the nursery had dirt/debris in the drawer of supplies.</p> <p>18. At 2:20 PM and 2:30 PM on 2/16/16, staff member #65 confirmed that nursing should be cleaning out the drawers of the warmers between patients, and not just cleaning the outside of the machines.</p> <p>19. At 12:30 PM on 2/17/16, interview with staff member #52, the vice president</p>			

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	of patient services, confirmed that there is no policy related to the between patient cleaning of equipment by nursing staff, but it is the expectation that this will be accomplished per standards of care practices.				