

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150091	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW HUNTINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 STULTS RD HUNTINGTON, IN 46750
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S 0000 Bldg. 00	The visit was for a licensure survey. Facility Number: 005081 Survey Date: 10/13/15 - 10/15/15 QA: JL 10/29/15 IDR Committee met on 12-07-15, tag S0322 changed, tag S0406 no changes & tag S0592 deleted. JL	S 0000		
S 0332 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures. Based on document review and interview, the facility failed to maintain	S 0332	Item # 1: ISDH Citation TAG # S332 Description: The facility failed to ensure that environmental	01/02/2016

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>competency documentation for cleaning and disinfecting in the restricted surgical environment for 1 environmental services (EVS) personnel (A25).</p> <p>Findings:</p> <p>1. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: "Perioperative and EVS personnel must ...complete competency verification activities that address specialized knowledge and skills related to the principles and processes of environmental cleaning ...Competency assessment measures individual performance, provides a mechanism for documentation, and verifies personnel have an understanding of facility policies ...Process monitoring must be a part of every perioperative setting as part of an overall environmental cleaning program. Process monitoring should include ...cleaning procedures [and] monitoring cleaning and disinfection practices ..."</p> <p>2. On 10-13-15 at 1100 hours, the administrator A1 was requested to provide documentation of process monitoring observations by a qualified person for the EVS staff providing terminal operating room (OR) cleaning and disinfecting services in the restricted</p>		<p>services (EVS) personal maintained competency documentation for cleaning and disinfecting in the restricted surgical environment for 1 EVS personnel</p> <p>Process Owners: Scott Amburgey; Sherri Robinson; Candace Rogers</p> <p>The following constitutes Parkview Huntington 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.</p> <p>WHO: The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers.</p> <p>WHAT: Concisely describe the actions completed. The 2014 AORN guidelines state that <i>"There are no universally accepted or mandated ways to perform or verify competency, and strategies to accomplish this differ among states. The goal of competency verification is to reassure the public that nurses have the knowledge, skills and judgment to provide safe</i></p>	

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	<p>surgical environment and none was provided prior to exit.</p> <p>3. The personnel file for A25 lacked documentation of process monitoring observations by a qualified person for the terminal OR cleaning services at the facility</p> <p>4. During an interview on 10-14-15 at 1510 hours, the director of facilities A5 confirmed that no documentation of process monitoring observations for the EVS staff A25 performing terminal OR cleaning and disinfecting was available.</p> <p>5. During an interview on 10-15-15 at 1140 hours, the infection control (IC) nurse A3 and A33 confirmed no documentation of process observations for EVS personnel performing terminal OR cleaning and disinfecting was available.</p>		<p><i>and ineffective care. " and "Perioperative and environmental services personnel must receive education and complete competency verification activities that address specialized knowledge and skills related to the principals of environmental cleaning"</i></p> <ul style="list-style-type: none"> • <input type="checkbox"/> Participation in the annual in service training completed is documented in Net Learning under the title "Housekeeping In Service for Surgery" • <input type="checkbox"/> Per policy entitled "Environmental Cleaning in the Perioperative Setting", the perioperative staff assesses the perioperative environment for cleanliness and takes action if needed. <p>WHEN: Please indicate the dates each action was completed. First 30-days (10/31/15 to 12/1/15)</p> <ul style="list-style-type: none"> • 11/2/15- Quality Accreditation and Executive Management met to review the Survey Report and Findings • 11/2/15- Participation in the annual in service training completed on as documented in Net Learning under the title "Housekeeping In Service for Surgery" • 11/2/15- Per policy entitled "Environmental Cleaning in the Perioperative Setting", the 	

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S 0394 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital		<p>perioperative staff assesses the perioperative environment for cleanliness and takes action if needed.</p> <p>Second 30-days: (12/2/15 to 1/2/16):</p> <ul style="list-style-type: none"> Documentation on annual evaluation that includes a competency assessment for terminal cleaning in the OR <p>HOW: Please describe how compliance will be sustained. On an annual basis the EVS staff will be in service on the terminal cleaning in the OR process. Validation of this process will include the perioperative staff assessment of the perioperative environment for cleanliness. Action will be taken if needed. Competency evaluation of terminal cleaning in the OR will be documented on an annual basis in the annual evaluation. This annual competency evaluation process will be the responsibility of both EVS supervisor and Infection Control. Each holding the other accountable for sustaining compliance.</p>	

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	<p>whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 8 contracted services. (CS1, CS2, CS3, CS4, CS5, CS6, CS7 & CS8)</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documentation indicated the following as contracted services: anesthesia equipment service by CS1, ionizing radiation badge monitoring by CS2, medical imaging equipment service by CS3, CS4 & CS5, medical physicist services by CS6, surgery sterilization service by CS7 and surgical waste disposal system service by CS8. Governing Board documentation dated 12-17-14 indicated a list of 31 contracted service providers was approved for renewal including CS1, CS3, CS4, CS5 and CS7 and the list failed to indicate the radiation badge monitoring service by CS2 or the medical physicist services by CS6. 	S 0394	<p>Item # 2 Citation TAG #S394</p> <p>Description: The Facility failed to maintain a list of all contracted services, including the scope and nature of the services provided, for 8 contracted services</p> <p>Process Owner(s): Doug Selig; Vicki Mickley and Rebeccah Farthing</p> <p>Units Involved: Administration</p> <p>The following constitutes Parkview Huntington 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.</p> <p>WHO:</p> <ul style="list-style-type: none"> The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. 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. The President is ultimately responsible for the corrective 	12/16/2015

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	<p>3. On 10-14-15 at 1120 hours, a list of contracted services was provided by the quality specialist A2. The list failed to indicate a provider for an anesthesia equipment service, 3 medical imaging services, 2 medical physics services, a surgical instrument sterilizer and a surgical waste disposal system.</p> <p>4. On 10-15-15 at 1020 hours, the quality specialist A2 and chief nursing officer A4 confirmed that a list of contracted services had not been maintained.</p>		<p>action and for overall and ongoing compliance.</p> <p>WHAT: Concisely describe the actions completed.</p> <ul style="list-style-type: none"> · The contract services list was updated and made available to the Hospital President. · The services will be reviewed by department leaders as appropriate. · The list of contracted services and recommendations will be forwarded to the Board for approval. <p>WHEN: Please indicate the dates each action was completed. First 30-days (10/31/15 to 12/1/15)</p> <ul style="list-style-type: none"> · 11/2/15 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. <p>Second 30-days: (12/2/15 to 1/2/16):</p> <ul style="list-style-type: none"> · The list of contracted services was updated · The list was forwarded to the Board for approval <p>HOW: Please describe how compliance will be sustained. Once per quarter, for the next year, we will ensure that the services listed below are accurately listed on the hospitals contracted services report. Compliance issues will be referred to administration for resolution.</p> <ul style="list-style-type: none"> · Anesthesia Equipment Service · Ionizing Radiation Badge 	

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S 0406 Bldg. 00	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to maintain its quality assessment and performance improvement (QAPI) program and failed to assure that all services including contracted services were evaluated and reviewed through the program for 31 contracted services.</p> <p>Findings:</p>	S 0406	<p>Monitoring</p> <ul style="list-style-type: none"> · Medical Imaging Equipment Service · Medical Physicist Services · Surgery Sterilization Service · Surgical Waste System Service <p>Item # 3 ISDH Citation TAG # S406 Description:Based on document review and interview, the facility failed to maintain its quality assessment and performance improvement (QAPI) program and failed to assure that all services were evaluated and reviewed through the program for 31 contracted services Process Owner(s):Doug Selig; Vicki Mickley, Scott Amburgey and Rebekkah Farthing</p>	02/03/2016

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	<p>1. The policy/procedure titled Plan for the Provision of Patient Care (approved 12-13) indicated the following: "The Hospital Board has delegated to the Hospital Board Quality Committee the responsibility to oversee and coordinate the various Patient Safety and Quality activities carried out within the hospital. This group ensures that appropriate monitoring, analyzing and improving of clinical and other process for all services takes place, as well as the communication of these activities hospital-wide."</p> <p>2. The health system Safety and Quality Strategic Plan 2015-2017 (approved 3-15) indicated the following: "The program evaluates all services, including services furnished by contract ... [and] ... information and infrastructure of the program are located in the Safety & Quality Plan appendices." The facility Safety and Quality Service Organizational Chart observed in the plan appendices indicated a medical staff committee titled Clinical Committee/Infection Control and indicated a hospital committee titled Patient Care with reporting responsibilities to the Board Quality Committee.</p> <p>3. The medical staff policy/procedure Clinical Committee Description</p>		<p>UnitsInvolved: Administration The following constitutes Parkview Huntington 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.</p> <p>WHO: The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers.</p> <p>WHAT: Concisely describe the actions completed.</p> <ul style="list-style-type: none"> • Quality Accreditation and Executive Management met to review the Survey Report and Findings. • The contract services list was updated and made available to the Hospital President. • The list of contracted services and recommendations will be forwarded to the Board for approval. <p>WHEN: Please indicate the dates each action was completed. First 30-days (10/31/15 to 12/1/15)</p> <ul style="list-style-type: none"> • 11/2/15 – Quality Accreditation and Executive Management met to review the Survey Report and Findings. <p>Second 30-days: (12/2/15 to 1/2/16):</p>		

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	<p>(approved 6-15) indicated the following: "The committee shall have standing membership of physicians appointed by the chief of the medical staff ..." The Clinical Committee Description failed to indicate if the scope incorporated the functions of the hospital-wide Infection Control committee and/or QAPI committee at the facility or if the Infection Control (IC) Nurse and hospital leadership staff in attendance were recognized as members during the medical staff meeting.</p> <p>4. On 10-13-15 at 1115 hours, the administrator A1 provided documentation titled Clinical Committee minutes for 2014 & 2015 and indicated the committee functioned as the IC and QAPI committee for the facility.</p> <p>5. Review of the 2015 Clinical Committee minutes dated 1-8, 2-5, 3-5, 4-2, 5-7 and 6-4 and the 2015 Board Quality Committee minutes dated 1-15 and 3-13 failed to indicate either committee reviewed the department and service-specific Measures of Success Dashboards provided by quality specialist A2 on 10-13-15 as evidence of QAPI program monitoring and compliance.</p> <p>6. On 10-15-15 at 1035 hours, quality specialist A2 confirmed the Patient Care</p>		<ul style="list-style-type: none"> • 12/18/15- The list of contracted services was updated • 12/18/15- The list was forwarded to the Board for approval <p>Third 30—days (1/3/16 to 2/3/16):</p> <ul style="list-style-type: none"> • □□□□□□□□ The scope of the Clinical Committee will be updated to clearly reflect oversight of the hospital-wide infection control program. · In order to ensure the hospital-wide, quality assessment and improvement program reflects consistent evaluation of the provision of patient care, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken, and follow-up, and review of contracted services the flow of this information will be retooled and the applicable documents will be updated to reflect the following communication progression: Patient Care Committee to Clinical Committee to Board Quality. The information will be reviewed and assessed by the Board Quality Committee at least quarterly. <p>HOW: Please describe how compliance will be sustained. Sustainment of this process will be achieved via the quality department's regulatory tracking matrix.</p>				

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	<p>Committee (PCC) was responsible for evaluating and reviewing the Measures of Success dashboards and a review of the PCC minutes dated 1-20, 2-17, 3-17, 4-21, 5-19, 6-16, 7-21 and 8-18 confirmed the committee reviewed the Measures of Success Dashboards including documentation of PCC recommendations or actions if needed.</p> <p>7. During an interview on 10-15-15 at 1120 hours, quality specialist A2 confirmed the Clinical Committee minutes dated 9-4-14 indicated a summary of the 8-19-14 PCC minutes was provided for review. The quality specialist A2 confirmed the Clinical Committee stopped reviewing the PCC documentation in 2014 upon the request of a standing member and confirmed the 2015 Clinical Committee and 2015 Board Quality meeting documentation failed to indicate the PCC minutes or Measures of Success Dashboards were presented or reviewed.</p> <p>8. Governing Board documentation dated 12-17-14 indicated a list of 31 contracted services was approved for renewal at the facility and the documentation failed to indicate the contracted services were evaluated or recommended for renewal through the QAPI program. The quality specialist A2</p>			

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S 0912 Bldg. 00	<p>was requested to provide documentation of QAPI program monitoring and/or recommendations for the 31 services provided by agreement and none was provided prior to exit.</p> <p>9. During an interview on 10-15-15 at 1035 hours, the quality specialist A2 confirmed that no documentation indicating the contracted services were evaluated and reviewed through the QAPI program was available.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 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.</p>			

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	<p>(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.</p> <p>(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, observation, and interview, the nursing director failed to ensure the implementation of its policy related to staff cleaning responsibilities in 3 locations toured. (In patient unit, Emergency Department & Newborn Nursery)</p> <p>Findings: 1. Review of the policy "Cleaning Responsibilities for Patient Care Personnel", no policy number, last approved on 4/2014, indicated under "Procedure": "A. Clinical areas will be kept clean and orderly...F. Patient care equipment should be cleaned, maintained, and/or removed from the room in the manner designated by the Centralized/Decentralized Equipment Model practiced in the facility...I. Cleaning of high touch surfaces and shared patient care equipment and supplies must occur whenever contamination is observed or suspected, between each patient use, and/or on a frequency as directed per policy</p>	S 0912	<p>Item # 5: ISDH Citation TAG #S912</p> <p>Description: Based on document review, observation and interview, the nursing director failed to ensure the implementation of its policy related to staff cleaning responsibilities in 3 locations toured. (Inpatient unit, Emergency Department & Newborn nursery.</p> <p>Process Owner: Doug Selig and Candace Rogers Units Involved: All Patient Care areas</p> <p><i>The following constitutes Parkview Huntington 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.</i></p> <p>WHO:</p> <p>The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a</p>	11/10/2015

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	<p>according to the location or surface...J. The following two tables list cleaning tasks designated for Patient Care Personnel, or their delegates."</p> <p>2. Table one, page 4 of the policy listed in 1. above, indicated that "Computers On Wheels, Patient Care Equipment (i.e. [such as] portable vital sign machines, scales...)" are to be cleaned "After every patient encounter".</p> <p>3. Table two, page 5 of the policy listed in 1. above, listed "Refrigerators and freezer compartments, microwaves,..." are to be cleaned "Every month and as needed".</p> <p>4. Review of the IP (in patient) "Terminal Cleaning Schedule" for various pieces of equipment, including the patient nutrition refrigerator, indicated the most recent refrigerator cleaning took place on 10/6/15, and had occurred monthly for each month of 2015.</p> <p>5. While on tour of the IP unit at 1:30 PM on 1/13/15, in the company of staff member #52, the VP (vice president) of patient care services, it was observed that the patient nutrition refrigerator had debris on the vegetable drawers, and under them, including the finding of a</p>		<p>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> <ul style="list-style-type: none"> · The Infection Preventionist is ultimately responsible for the corrective action and for overall and ongoing compliance. <p>WHAT/WHEN: Concisely describe the actions completed.</p> <ul style="list-style-type: none"> o 11/2/15– Quality Accreditation and Executive Management met to review the Survey Report and Findings. o 11/9/15--The cleaning log has been updated and has been distributed to all patient care areas for their use o 11/10/15--Education to staff on appropriate cleaning methods as well as the policy entitled <i>Cleaning Responsibilities for Patient Care Personnel</i> <p>HOW: Please describe how compliance will be sustained:</p> <ul style="list-style-type: none"> · Staff is expected to clean spills immediately upon occurrence · Infection control reviews refrigerator cleanliness during monthly department rounding · Cleanliness will be assessed and monitored during quarterly Environment of Care Rounding · Results of monthly IPC rounding and EOC rounding are reported to Safety Committee 	

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	<p>receipt dated 2/3/15.</p> <p>6. Interview with staff member #52, confirmed cleaning of the refrigerator monthly was not including the vegetable drawers and under them, as indicated by the debris and receipt found.</p> <p>7. Review of the "Warming Cabinet Cleaning Log" for the ED (emergency department) clean utility room, indicated cleaning had occurred on 10/13/15.</p> <p>8. While on tour of the ED at 1:20 PM on 10/14/15, in the company of staff member #52, it was observed that there were dried drips/spills of a liquid substance noted on the bottom shelf of the patient nutrition refrigerator.</p> <p>9. At 1:30 PM on 10/14/15, interview with staff member #60, an ED tech, confirmed this staff member does the cleaning of the refrigerator on the same days they clean the blanket warmer, thus the document provided and reviewed in 7. above, indicated the refrigerator was cleaned on 10/13/15.</p> <p>10. Interview with staff member #52 at 1:35 PM on 10/14/15 confirmed that if the ED refrigerator had been cleaned on 10/13/15, but now had dried drips of liquid present, someone should have</p>			

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S 1186 Bldg. 00	<p>cleaned it up again, not leaving it as is.</p> <p>11. At 1:45 PM on 10/14/15, while on tour of the newborn nursery in the company of staff member #51, the quality and risk manager, it was observed that a vital signs monitor on wheels had a large accumulation of dust on the lower portion/base of the machine.</p> <p>12. At 1:45 PM on 10/14/15, and 10:20 AM on 10/15/15, interview with staff member #51 confirmed nursing staff had not followed the patient care equipment cleaning policy in regards to the dust found on the portable monitor in the newborn nursery on 10/14/15.</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: (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</p>						

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	<p>contains provisions for the following:</p> <ul style="list-style-type: none"> (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. <p>Based on document review and interview, the safety program failed to ensure that quarterly fire drills were performed for 1 of 12 quarterly drills in 2014 and 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Fire Safety Management 2015 (approved 2-15) indicated the following: " Fire drills are conducted by the Security Department monthly, once per shift per quarter in the hospital. " 2. Review of fire drill documentation failed to indicate a fire drill was performed during the afternoon shift for the 4th quarter 2014 (November). 3. During an interview on 10-14-15 at 1510 hours, the safety officer and director of facilities A5 confirmed that no afternoon fire drill was performed during the 4th quarter 2014 as scheduled. 	S 1186	<p>Item #6: ISDH Citation TAG #S1186 Description: The Safety Program failed to ensure that quarterly fire drills were performed for 1 of the 12 quarterly drills 2014 and 2015 Process Owner(s): Everett Carroll Unit(s) Involved: Public Safety The following constitutes Parkview HuntingtonHospital'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.WHO: · The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. 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. · The Director of Public Safety is ultimately responsible for the corrective action and for overall and ongoing compliance. WHAT:</p>	12/01/2015

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			<p>Concisely describe the actions completed. · The Public Safety Site Supervisor has been identified as the primary person responsible for tracking and trending the fire drill completion for all areas of the hospital · The Public Safety Deputy Lieutenant has been identified as the secondary person responsible for fire drill completion · A fire drill evaluation will be completed and be submitted to the Public Safety Site Supervisor after each drill is completed · A hospital wide fire drill summary will be used to track and trend that fire drills are completed per regulation WHEN: Please indicate the dates each action was completed. · 11/12/15-Key leaders identified for accountability of fire drill completion · 12-1-15 Public Safety Officers educated to process and expectations HOW: Please describe how compliance will be sustained. All fire drill activities will be reported to the safety committee on a monthly basis to assure accountability. This will include submission of the hospital wide fire drill summary to ensure oversight of the process.</p>	