

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2012
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NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 6/18/12 through 6/19/12</p> <p>Facility Number: 005019</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN PH Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: claughlin 06/27/12</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0406	<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.</p> <p>Based on document review and staff interview, the facility failed to ensure Housekeeping, Biohazardous Waste, Oncology, Pediatrics and Tissue Transplant services were part of the hospital's comprehensive quality assessment and improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. The Quality Improvement Plan last reviewed 6/18/2012 states, " Quality and performance improvement activities will include the monitoring and evaluation of the processes and outcomes, which affect patient care and services. These include all department/services, functions, dimensions of care, and staff as well as customers and age groups.</p>	S0406	<p>(2), (3) The five (5) hospital services listed have added the following monitors to correct this deficiency.a. Housekeeping has begun monitoring the process for terminal cleaning (17 high touch areas) of patient rooms after discharge. Fifteen rooms will be monitored per quarter: 7 M/S rooms, 5 ER rooms and 3 CCU rooms.b. Biohazardous waste will be monitored by Facilities for the timeliness and reconciliation of the monthly manifest report listing items picked up. The Director of Facility Services will be responsible for this.c. Oncology/Infusion Clinic will begin monitoring PICC line placements (successful/unsuccessful); physician presence during the first dose of chemotherapy at GGH; and length of time to schedule an initial referral</p>	07/02/2012

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	<p>Departments/services include all clinical departments/services; all support department/services and all administrative department/services."</p> <p>2. The hospital contracted and in-house services were reviewed for being monitored by the hospital Quality Improvement Program. The minutes and data QAPI meetings were reviewed with staff member #2 for 2011 and 2012. The QAPI minutes and data lacked documentation that 5 hospital service were evaluated by the Quality and Performance Improvement Program: housekeeping; biohazardous waste; oncology; pediatrics and tissue transplant.</p> <p>3. At 2:45 PM on 6/19/2012, staff member #2 indicated QA has not been monitoring housekeeping; biohazardous waste; oncology; pediatrics and tissue transplant.</p>		<p>appointment.d. Pediatrics will be monitoring immunization status and height/weight (in kilograms) on the chart.e. Tissue transplant will be monitoring the daily room temperature (as recommended by the distributor) of where the tissue is stored. A log will be kept and staff will inital the log each day. All of these monitors will be included in the appropriate department's quarterly Performance Improvement Committee (PIC) report and the department manager/director is responsible for the quarterly report. These monitors will be tracked for one year and then the PIC will make recommendations for further monitoring requirements.</p>		

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, document review and interview, the facility failed to ensure chemical Cidex OPA was used properly on health care equipment that comes in direct contact with patients for Imaging Department and failed to maintain autoclaves per facility policy for 2 of 2 autoclaves.</p> <p>Findings included:</p> <p>1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices, in the Imaging Department. Cidex OPA manufacture sheet requires: 1) The user should be adequately trained in the demonstration</p>	S0596	(1), (2), (3), (4) High level disinfection of the transvaginal probe will continue per recommendations by the CDC and American Institute of Ultrasound (AIUM). Cidex OPA will continue to be the disinfectant that is utilized. The GGH policy and procedure "Use of Cidex OPA Solution as a High Level Disinfectant in Radiology" has been revised to meet the rinsing guidelines as specified by the manufacturer. The Radiology staff was educated regarding this new procedure on 6/20/2012. Following is the new rinsing procedure:a. Following the removal from CIDEX OPA Solution, thoroughly rinse the probe by immersing it completely in a large volume of water. Fill 3 buckets each with 2 gallons of tap	07/12/2012			

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	<p>and disinfection of semi-critical medical devices and the handling of liquid chemical germicides, 2) Cidex OPA stored in it's original container 59 to 86 degrees Fahrenheit and is in a well-ventilated low traffic area, 3) Once opened, the unused portion of the solution may be stored in the original container up to 75 days until used, 4) Record the date the container was opened on the container label or in a log book, record the date the solution was poured outside the original container and the product must be used within 14 days, 5) Manual processing - Immerse device completely, filling all lumens and eliminating air pockets in Cidex OPA solution for a minimum of 12 minutes at 68 degrees F or higher 6) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done 7) test strips should be used each time before Cidex OPA is used to measure for the proper concentration 8) exhaust hoods are required when using Cidex OPA, 9) Use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns, and 10) the lids for the test strips and solution need to be tight fitting.</p> <p>2. Radiology policy Use of Cidex OPA</p>		<p>water for rinsing purposes. b. Totally immerse the probe in one of the 2 gallon buckets of water for a minimum of 1 minute of duration. c. Repeat the rinsing procedure TWO (2) additional times, for a total of THREE (3) RINSES in the remaining two buckets each for a minimum of 1 minute of duration. d. Discard the rinse water. Do not reuse the water for rinsing or any other purpose. This new process will be monitored twice per month by the Radiology Director for a year and reported to Performance Improvement Committee for quality purposes. At the end of the year, the PIC will determine the need for further monitoring requiriements. (5, 6) The GGH "Steam Autoclave Maintenance" procedure will be reviewed with the surgical/central sterile staff at their unit meeting on July 12, 2012. This will be a on a daily schedule. The responsible person will be the the Director of Surgical Services. This will be monitored in their departmental PI and reported quarterly to the PIC.</p>				

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	<p>solution as a High Level Disinfectant last approved 7/20/2012 states, "Immerse in tap water 3 separate times for a minimum of 1 minimum of 1 minute each rinse, taking care to use fresh water for each rinse. Use large volumes of water to remove Cidex OPA residues, Residues may cause serious side effects."</p> <p>3. At 12:10 PM on 6/19/2012, staff member #8 indicated Cidex OPA was used for disinfecting vaginal probes in the Imaging Department. The staff member indicated the probes would be washed with soap and water and wrapped in a towel then taken downstairs to the ETO room. The staff member said the probes are rinsed in the hand sink for 3 minutes as defined in their policy. The staff member indicated the probes are not rinsed as the manufacturer label specifies and he/she confirmed that he/she was unaware of this procedure. The staff member indicated he/she has done this rinsing technique for years.</p> <p>4. The ETO room was observed with a counter for the storage of the Cidex OPA and a porcelain hand washing sink with a eye washing station. The room does not have any separate containers for the rinsing procedure or another way to properly rinse the vaginal probes as specified by the manufacturer.</p>						

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	<p>5. Facility policy titled "STEAM AUTOCLAVE MAINTENANCE" states under procedure on page 1: "Daily Maintenance: 1. Wash inside of chamber..... 2. Rinse..... 3. Remove chamber drain strainer. Clean out lint and sediment....."</p> <p>6. Staff member #N4 indicated in interview at 1:30 p.m. the sterilizers, including the drain strainer are cleaned on a weekly basis.</p>	S0596	<p>(1), (2), (3), (4) High level disinfection of the transvaginal probe will continue per recommendations by the CDC and American Institute of Ultrasound (AIUM). Cidex OPA will continue to be the disinfectant that is utilized. The GGH policy and procedure "Use of Cidex OPA Solution as a High Level Disinfectant in Radiology" has been revised to meet the rinsing guidelines as specified by the manufacturer. The Radiology staff was educated regarding this new procedure on 6/20/2012. Following is the new rinsing procedure: a. Following the removal from CIDEX OPA Solution, thoroughly rinse the probe by immersing it completely in a large volume of water. Fill 3 buckets each with 2 gallons of tap water for rinsing purposes. b. Totally immerse the probe in one of the 2 gallon buckets of water for a minimum of 1 minute of duration. c. Repeat the rinsing procedure TWO (2) additional times, for a total of THREE (3) RINSES in the remaining two buckets each for a minimum of 1 minute of duration. d. Discard the rinse water. Do not reuse the water for rinsing or any other purpose. This new process will be monitored twice per month by the Radiology Director for a year and reported to Performance Improvement Committee for quality purposes. At the end of the year, the PIC will determine</p>	07/12/2012	

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			the need for further monitoring requiriements. (5, 6) The GGH "Steam Autoclave Maintenance" procedure will be reviewed with the surgical/central sterile staff at their unit meeting on July 12, 2012.This will be a on a daily schedule. The responsible person will be the the Director of Surgical Services. This will be monitored in their departmental PI and reported quarterly to the PIC.	

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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review, the facility failed to ensure 2 of 5 health care food service personnel have had Hep-B vaccination or a signed refusal for receiving the vaccination. (#10 and #11)</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Infection Control Plan policy last approved 8/2010 indicates the hospital will adhere to CDC requirements. 2. CDC requirement for Health Care personnel (HCP) who are not not expose to blood and/or body fluids states, "For non-responders: HCP who are non-responders should be considered 	S0606	<p>The policies, Hepatitis B Vaccine and Occupational Bloodborne Pathogens Exposure Control Plan have been revised to reflect current CDC guidelines, removal of job classifications.</p> <p>All healthcare workers are now considered susceptible to HBV. All Gibson General Hospital employees will be offered the Hepatitis B vaccine and counseled regarding precautions to prevent HBV infection or they may sign a declination form with the understanding that if they should change their mind, the vaccine will be available to them.</p> <p>Employee personnel files #10 and #11 have been updated and are now complete. The Business Health staff will be rededucated</p>	07/18/2012			

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	<p>susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg) -positive blood.1 It is also possible that non-responders are persons who are HBsAg positive. Testing should be considered. HCP found to be HBsAg positive should be counseled and medically evaluated."</p> <p>3. Personnel Files were reviewed with staff member #4 at 3:00 PM on 6/18/2012. Staff member #10 and #11's files lacked documentation of having the Hep-B vaccination or a signed refusal of not receiving the vaccination series.</p>		<p>regarding the revision of these policies on July 11, 2012. Business Health Services maintains an electronic employee immunization record. All new employee records will be monitored on a quarterly basis for completeness and this will be reported at the Performance Improvement Committee by the BHS director.</p>		

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S0612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation, document review and staff interview, the facility failed to ensure the linen washed in the Laundry Department is being washed as CDC recommends for washing in a health care setting and per hospital policy.</p> <p>Findings included: 1. Laundry policy last reviewed 3/7/2012 states, "Water used for washing linens in the hospital shall not exceed 180 degrees F. Normal washing temperature is 160 degrees F. AmeriClass Systems Incorporated services the laundry and provides laundry supplies. They submit a monthly preventive maintenance program services report containing the following: Information for testing, results and procedures used in washing; Test results</p>	S0612	<p>(3) The hospital laundry has a total of 9 wash cycles, and HP Products provide the chemicals:Alkali-Break, Reliance-Suds, Bleach-Bleach, Outright-Sour and Value Soft-Softner. Each cycle is based on various levels of soiled linen:1-Heavy Soil 2-Kitchen 3-Pads 4-Pillows 5-Sheets 6-Standard wash 8-Towels and Washcloths 9-Heavy Soiled Surgery 19-Surgery Towels (No Bleach) GGH has 3 institutional-type washers, the middle washer says "Surgery Linen Only", because it is set up specifically for Surgery linen cycles 9 & 19. A water temperature gauge has been installed for all three washers and the Environmental Services Manager will monitor and record</p>	07/18/2012			

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	<p>for machines for proper functions, controls and correct temperatures; and an inventory of supplies used and the dollar factor for out cost of operation. Copies of this report are on file in the Facilities Services Department for tracking and informational purposes."</p> <p>2. CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. The use of chlorine bleach assures an extra margin of safety. A total available chlorine residual of 50-150 ppm is usually achieved during the bleach cycle. Chlorine bleach becomes activated at water temperatures of 135°F-145°F (57.2°C-62.7°C)."</p> <p>3. At 11:55 AM on 6/19/2012, the Laundry Department was toured. The supplies are provided by HP Products. The chemicals provided by HP Products are: Sour; Suds; Softener; Bleach; and Alkali. Posted on the wall, a chart noted the 7 cycles the washers could operate in. The cycles specify how much of each chemical may be supplied during the configured cycle; 1, 2, 3, 4, 5, 6, and 8. The department was observed with 3 industrial ODEL Melnor E-P Plus</p>		<p>those readings daily for 3 months and recorded on a log evidenced by initials of that staff member. After these 3 months, the temperature will be monitored weekly unless the temperature falls below the minimum 160 degrees F. Then it will be monitored daily until it registers a consistent temperature equal to or above the 160 degrees F. Once that occurs, it will return to a weekly monitor. This temperature log will become part of the department's QI and will be presented quarterly at the PIC meeting. (4) GGH now has between 160-163 degrees F. going into each washer for each cycle run. We are currently using low temperature chemicals with a cycle run time of 42 minutes and a minimum water temp of 160 degrees F. covering both areas of high temps and the use of low temperature chemicals. Cycles 9 & 19 are used for Surgery linen alone. Cycle 9 is used for heavily soiled linen with bleach. Cycle 19 is used for instrument towel wrappers where no bleach is used. (5) All cycles (except Cycle 19) have a minimum of 125 ppm of chlorine going into each cycle as recommended by the CDC. The responsible person will be the Director of Facility Services. The Laundry staff will also be inserviced regarding these procedure changes on July 9, 2012.</p>				

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	<p>washers that are currently in operation (50 and 50 pound washers). The department had a non-industrial top loading washer that was out of service. The middle washer of the 3 E-P Plus washers had a sign posted on the window stating, "Surgery Linen Only." The temperature gauge to the water heater located down the hall registered 157 F. The two end washers did not have a water temperature gauge on them; however, the middle washer used for surgery linen had a dial water temperature gauge on it.</p> <p>4. At 12:10 PM on 6/19/2012, staff member #6 indicated the water heater only provides 153 to 157 F hot water to the washers and the washers will maintain the water temperature through the calibrated cycles. The staff member indicated the washers are high temperature washers. Staff member indicated there are 7 cycles posted but there were also 2 additional cycles; cycle-9 (Heavy soiled linen from surgery); cycle-19 (surgery wraps). Cycle 19 has no bleach added because tests discovered the bleach oxidized the stainless steel surgical equipment and turned the equipment a rusty color. Both cycles are done in the middle washers where no bleach would be added (Surgery Linen Only). None of the washers have a booster heater and the staff member confirmed the washers never receive 160</p>			

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	<p>F hot water. The staff member indicated he/she does not have records noting the water temperature during each cycle and does not have monthly preventive maintenance program services reports from HP Products noting if the chemicals were calibrated correctly.</p> <p>5. At 12:30 PM on 6/19/2012, staff member #6 contacted HP Products to provide documentation of the chemical dispensing system. A memorandum from the vendor dated 6/19/2012 at 1:12 PM CST states, "With the information that I currently have on hand the following should be the ounces that are going into the machines at Gibson General (Cycle-1, cycle-2, cycle-3, cycle-4, cycle-5, cycle-6, and cycle-8). Looks like all cycles are getting a minimum of 125 ppm of bleach so they are meeting CDC and Federal guidelines on sanitation. However, the memorandum explained what each cycle should get but was not documentation of what each cycle actually received. The memorandum also did not mention the two additional cycles for surgery linen that do not receive bleach at all.</p>				

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S1118	<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.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (4) instances Northeast offsite Audiology Department, St. Vincent's Women Hospital's Frozen Section Room, Imaging Department, and Maintenance Department.</p> <p>Findings included:</p> <p>1. Safety Officer policy last reviewed 6/8/2012 indicates the hospital Safety Officer manage and oversee all hospital safety programs in order to maintain a safe environment for patients, visitors, and personnel as it relates to the facility's OSHA hazard communication program.</p> <p>2 Because 1910.178 does not have a</p>	S1118	<p>(1), (2) and (3): GGH has ordered and will install a free standing eye wash station in the primary janitor's closet which will provide coverage for both the battery operated floor scrubber as well as the bulk chemicals that are stored in the janitor's closet. Work is to be completed within 30 days. After installation staff will be inserviced on this new equipment by the Department Director and a PM schedule will be established according to the manufacturer's recommendations. The Facilities manager will be responsible for monitoring and reporting these PMs quarterly at the PIC meeting.(4), (5) and 6: All items that were stored in the mechanical room inappropriately have been moved away from the switch gear and electrical panels and</p>	07/20/2012			

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	<p>specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 12:00 PM on 6/19.2012, the main janitorial chemical storage and equipment room was inspected. One wall had a storage shelves stretching the length of the room. The shelves were storing assorted concentrated chemicals: delimer, liquid chrome cleaner, spray & buff scrubber floor cleaner, etc. The manufacturer's label on assorted chemicals required 15 minutes of continuous eye flushing if chemical comes in contacts with a person's eyes. The opposite wall to the chemical storage shelves was a 12-volt battery operated walk-behind industrial floor scrubber. The room was observed without an eye</p>		<p>stored in an appropriate location. This was completed on June 29, 2012. The floors adjacent to the switch gear and electrical panels will be marked using warning tape indicating that no items shall be stored directly within 36 inches in front of or adjacent to the switch gear or electrical panels. The tape has been ordered and work will be completed by 07/20/12. Staff (to include facilities staff, managers and directors) will be inserviced regarding proper storage around the switch gear and electrical panels. This will be done at the next Diectors/Managers meeting to be held on 07/26/12. Monthly monitoring of these areas will be done by the facilities director and reported quarterly at the PIC meeting.</p>				

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	<p>washing station. The nearest eye washing facilities were located behind down the hallway in the kitchen or in the maintenance/mechanical room. The distance to both eye washing stations have several obstacles before a person can reach the eye washing station in case of an emergency.</p> <p>4. Life Safety Management Program policy last reviewed 6/18/2012 states, "Gibson General Hospital holds safety as a high priority focus for all patients, visitors and employees. In order to ensure safety in the event of a fire, this organization will adhere to the guidelines by the 2000 Edition of the Life Safety Code."</p> <p>5. At 11:15 AM on 6/19/2012, building A 1st floor Mechanical Room was observed storing a pneumatic bed and mattress in front of high voltage electrical panel. At 12:05 PM, a second mechanical room was toured. The second mechanical room was observed storing heavy accumulation of supplies in front of high voltage electrical boxes. The supplies were in direct contact of the electrical panels. The supplies included cardboard boxes of supplies, assorted parent equipment, etc. The corner area of the room where the electrical equipment was located had an appearance of being</p>						

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	<p>cluttered and disarray.</p> <p>6. At 12:25 AM on 6/19/12, staff member #3 indicated the storage of supplies in the 2 mechanical rooms should not be within 36 inches of electrical panels. This storage requirement would prevent against electrical fires. The staff member confirmed the 2 mechanical rooms need to be cleaned up by his staff and trained on proper storage near electrical panels and electrical equipment.</p>				

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on Environmental Service's walk-behind automatic floor scrubber as recommended by the manufacturer.</p> <p>Findings included:</p> <p>1. The Advance industrial automatic floor scrubber operation manual specifies the machine to have daily, weekly, monthly, and yearly preventive maintenance checks.</p> <p>2. At 1:30 PM on 6/19/2012, the staff member indicated he/she could not provide documentation of routine preventive maintenance on the floor scrubber. The staff member indicated the hospital had the machine for about 9 months and Environmental Services has</p>	S1164	<p>(1) and (2): GGH has generated re-occurring Preventive Maintenance (daily, weekly, monthly and yearly) work orders to maintain the Advance floor scrubber. In addition we have created a work order log that will address these PMs which will be reported quarterly at PIC. Floor maintenance staff will be educated on the new PM procedure and this will be completed by 07/18/12.</p>	07/18/2012			

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	not recorded any routine preventive maintenance as recommended by the manufacturer.			

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and staff interview, the facility failed to ensure the CCU Lifepak 20 Defibrillator was discharged daily and initial entries were not routinely recorded on the days the ER and CCU Lifepak 20 defibrillator/monitor was checked.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Lifepak 20 Defibrillator/Monitor operation instructions requires the defibrillator to be checked each day.. 2. Crash Cart Checks policy last reviewed 6/18/2012 states, "A user test will be performed on the Lifepak 20 each day. This will be in addition to the daily auto test that is performed by the machine at 0300. The crash cart will be checked each day by a member of the nursing staff." 3. At 12:30 PM on 6/19/2012, staff 	S1168	The Nurse Manager will monitor that the Lifepak 20 Defibrillator/Monitor will be discharged daily as per CCU policy. The CCU staff was educated about daily discharging of the defibrillator at the ER/CCU unit meeting held on 6/28/2012 at 0700 and 1900. Staff initials, instead of checkmarks, will be used to verify the daily discharges. This will continue to be reported quarterly at the Performance Improvement Committee meeting.	06/28/2012

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	<p>member #14 indicated the CCU will never be closed. There will be days the CCU will not have patients; however, the CCU will be ready everyday if when ER assigns a patient to CCU. The staff member indicated nursing staff would be called in if a patient was assigned to CCU.</p> <p>4. The Crash Cart logs were checked for daily discharge of the Lifepak 20 defibrillator/monitor located in the CCU between April 1 through June 18, 2012. The logs revealed the defibrillator was not checked 26 days of the 79 days. Twenty-five days were marked closed and defibrillator was not checked; and the other day the defibrillator was never marked it was checked on the crash cart.</p> <p>5. The Crash Cart logs were checked for daily discharge of the Lifepak 20 defibrillator/monitor located in the CCU and ER between April 1 through June 18, 2012. A 'check mark' and not a nursing staff initial was recorded onto the monthly logs for; 52 of 52 CCU data entries; 32 of 79 data entries for ER. The 'check mark' instead of a staff member initial was not reliable documentation a staff member performed the defibrillator daily checks.</p>			

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