

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150112	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2015
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NAME OF PROVIDER OR SUPPLIER  COLUMBUS REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E 17TH ST COLUMBUS, IN 47201
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Dates of survey: 8/24/15 through 8/26/14  Facility number: 005099  QA: cjl 09/14/15	S 0000		
S 0178  Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)  (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.  Based on observation and interview, the hospital failed to post a current license at three offsite (Marr Road Outpatient Therapy, The Audiology & Wound Care Center [H] and The Rehabilitation Center [K]) premises of the hospital system toured.  Findings:	S 0178	S 01781. How are you going to correct the deficiency?1.a. Copy of Hospital License posted at the off-site Marr Road Outpatient Therapy and the Audiology & Wound Center, the Rehabilitation Center1.b. Copies of Hospital License are being made, frames ordered and will be posted at all patient service locations, including off-site locations. 2.	10/25/2015

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>1. While touring the offsite Marr Road Outpatient Therapy on 8/26/2015 at 0830 hours, it was noted that the facility did not have a license posted anyplace in the building.</p> <p>2. Staff member #N-13 (Director) concurred with this finding and indicated that administration was not aware of this requirement.</p> <p>3. On 8/25/15 at 9:00am, during tour of the hospital's off-site H, it was observed that the facility did not have a copy of the hospital license posted.</p> <p>4. On 8/25/15 at 9:00am, A2, Manager of Protective Services, and O3, Rehabilitation &amp; Mental Health Services Director, indicated the facility did not have a copy of the hospital license posted in off-site facility H.</p> <p>5. On 8/26/15 at 8:30am, during tour of the hospital's off-site K, it was observed that the facility did not have a copy of the hospital license posted.</p> <p>6. On 8/26/15 at 8:30am, P2 (also identified as O3), Rehabilitation &amp; Mental Health Services Director, indicated the facility did not have a copy of the hospital license posted in facility</p>		<p>How are you going to prevent the deficiency from recurring in the future?2.a. Added to annual schedule for Planned Event in Computerized Maintenance Management System. Refer to Procedure Tasks.3. Who is going to be responsible for 1 and 2?3.a. Director of Facilities and Materials Management4. By what date are you going to have the deficiency corrected?4.a September 24, 20154.b. October 25, 2015</p>				

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S 0610 Bldg. 00	<p>K.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation and interview, the infection control committee failed to provide for a program of food disposal beyond expiration/best by date for all personnel involved in food handling for 2 areas of the hospital (occupational</p>	S 0610	S 06101. How are you going to correct the deficiency?1.a. The out-dated food items in the OT kitchen cabinets were discarded on August 24, 2015. Food Services Policy 321, Infection Control was revised to specify that " all non-perishable food will	09/22/2015

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	<p>therapy &amp; oncology).</p> <p>Findings:</p> <p>1. On 8/24/15 during tour of the hospital, between 3:00pm and 4:45pm, in the presence of A1, Director of Facilities and A2, Manager of Protective Services, the following was observed:</p> <p>a) In the Occupational Therapy (OT) in-patient kitchen cabinets were the following food items with expiration/best by dates as indicated: 1 package Sugar cookie mix, 27Dec2014; 1 package Pasta Roni, May 17, 15; 1 package Mashed Potatoes 18Feb2015; 1 box Banana muffin mix 2/19/15 &amp; and 1 box Banana muffin mix 3/25/15. Occupational therapists S5 and S6 were also present.</p> <p>b) In the Oncology department, in a kitchenette/food storage area was the following: 3 packages of Instant Breakfast mix, Dec12, 2013; various single packaged crackers and packaged drink mixes stored in bins without a discard by date/indication. S8, Manager of the Cancer Center was present.</p> <p>2. On 8/26/15 at 3:30pm, S11, Food Services Manager, and A4, Director of Clinical Quality Management, indicated the facility did not have a policy addressing storage and/or disposal of expired food items, but that all areas of</p>		<p>be checked weekly for expiration dates. Expired items will be discarded."1.b. The outdated food items in the Oncology Unit were discarded on August 27, 2015. Food Service Policy 232, Nourishment Supplies, was revised on September 22, 2015 to include: "Where cases of non-perishable items, which are not labeled with clear Use By Dates, are stocked in a unit, the Food Service staff or receiving staff will write the Use By Date on the side of the container. The Use By Date is 2 months from the stock date for dry items such as crackers and 6 months for peanut butter." The policy applies to the area for the stocking of bulk items.2. How are you going to prevent the deficiency from recurring in the future?2.a. The OT in-patient kitchen area has been added to the Food Services staff stocking list to be checked weekly. 2.b. The Manager reviewed the items which were expired in the Oncology area and either discontinued stocking those items or reduced the par levels to match the item usage. Food Service staff have been instructed to check all food items in unit kitchens.3. Who is going to be responsible for numbers 1 and 2?3.a. Food and Nutrition Services Manager4. By what date are you going to have the deficiency corrected?4.a. September 22, 2015</p>		

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S 0754 Bldg. 00	<p>the hospital are expected to dispose of expired foods by the date indicated on the product. S11 also indicated that bulk supplied food items without an individual expiration date should somehow be labeled prior to individual storage when the expiration/best by date is indicated on the primary container.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p><b>Based on document review and staff interview, the hospital failed to complete all documentation for evidence of informed consent using procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state</b></p>	S 0754	S 07541. How are you going to correct the deficiency?1.a. Starting September 25, 2015 Nurse Managers will pull the blood policy and a copy of the blood consent and review in their staff meetings. Each staff member will be given a copy of the policy and the consent form for their reference. 2. How are you going to prevent the deficiency from recurring in the future?2.a. Once each week, the nurse manager or designee will	10/31/2015

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	<p><b>law for two of twenty patients receiving blood.</b></p> <p><b>Finding included:</b></p> <p><b>1. The policy, "Blood/Blood Product Transfusion, Policy/Procedure Code: PC-C 00015 r6-1, reviewed 5/22/15, read:</b></p> <p><b>"If the consent is signed more than thirty (30) days prior to the date of admission, the patient must reconfirm his/her consent by signing the appropriate space in the section titled 'Reconfirmation."</b></p> <p><b>2. Two patients receiving four blood units had missing consent forms including:</b></p> <p><b>Patient #14</b> --Unit #14A, administered on 8/14/2015 at 1600 and unit 14B, administered on 8/14/2015 at 1325 had each been administered without benefit of an in-date patient consent.</p> <p><b>Patient #15</b></p>		<p>perform an open chart audit review on at least one patient who has had blood product administration (if transfusion occurred on unit) to validate the completion of or current status of the blood consent. 2.b. If an error is found, there will be direct feedback and coaching with the staff who has administered the blood.2.c. If any error is found, there will be a review in the shift huddle as a reminder to all staff.2.d. The nurse manager will report findings to the Director of Nursing in the monthly meetings starting October 2015.3. Who is going to be responsible for number 1 and 2 above?3.a. Director of Nursing4. By what date are you going to have the deficiency corrected?4.a. September 25, 2015 start pulling policy and consent and review at staff meetings. 4.b. Staff meetings to be completed by October, 31, 2015.</p>		

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S 0952  Bldg. 00	<p><b>--Unit #15A, administered on 8/13/2015 at 0900 and unit 15B, administered on 8/13/2015 at 1025 had each been administered without benefit of an in-date patient consent.</b></p> <p><b>3. On 8/24/2015 at 11:00 a.m., staff member #5 acknowledged that the above-listed patients had received blood units without benefit of completed consent forms prior to their respective administration.</b></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 document review and interview, the facility failed to administer blood transfusions in accordance with approved medical staff policies and procedure for one of twenty patients and</p>	S 0952	S 09521. How are you going to correct the deficiency?1.a. Starting September 25, 2015 Nurse Managers will pull the blood policy and review in their staff meeting the requirement to	10/31/2015			

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	<p>failed to ensure that Registered Nurses had been instructed regarding errors on blood administration documentation.</p> <p>Finding include:</p> <p>1. The policy, "Blood: Packed Cells, Fresh Frozen Plasma Transfusion", Policy/Procedure Code: PC-B-1 00007 r10-0, read: "Record fifteen-minute vital signs on the Transfusion TAG and electronic record--a plus or minus 5 minutes of the assessment check will be allowed."</p> <p>2. In review of one patient receiving two blood units, one of these received-units did not have complete documentation, per policy, on the Crossmatch Transfusion Tag record form including:</p> <p>Patient #10 --Unit 10A, was administered on 8/18/2015 at 1325: This unit had been started 1325; however, the 15 minute vitals had been documented at 1348 which was at 23 minutes in lieu of at 15 minutes (+/- 5 minutes) allowed per policy.</p> <p>3. On 8/24/15 at 11:15 a.m., Staff member #5 acknowledged that the above-listed patient blood unit's 15 minute vitals had been documented at 23</p>		<p>complete blood tags. Each staff member will be given a copy of the policy for their reference.2. How are you going to prevent the deficiency from recurring in the future?2.a. All blood tags will be reviewed for completeness by the Patient Care Coordinator/Shift Charge on duty beginning September 21, 20152.b. Blood Bank staff will follow process of sending remaining blood tag errors to the nurse managers for follow up disciplinary action per policy.2.c. Any case where there was not follow up action (disciplinary action for staff per policy guidelines) recorded and sent back to lab within 2 weeks, the error and lack of manager response will be reported to the appropriate director for follow-up.2.d. Incomplete blood tags will be reported to Nursing Leadership Forum each month for review.3. Who will be responsible for numbers 1 and 2? 3.a. Director of Nursing and Lab Manager4. By what date are you going to have the deficiency corrected?4.a. September 25, 2015 Nurse Managers will begin to review at staff meetings4.b. Staff meetings to be completed by October 31, 2015</p>		

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S 1118 Bldg. 00	minutes.  4. Hospital policy Blood: Packed Cells, Fresh Frozen Plasma Transfusion, last updated 9/4/2014, indicates: The Manager of patient care areas is responsible for: 1.) Follow-up on data for process errors including process improvement activities, when applicable. 2.) Following disciplinary action process with staff as identified on Blood Bank Quality Assurance form.  5. Review of blood administration documentation errors for 2015 indicated that there were five errors noted by Quality Assurance auditing. Two of the five error reports to unit managers lacked documentation that the unit managers had talked to the nurses involved or taken any disciplinary action.  6. Staff member #4, Director of Clinical Quality, concurred with these findings.  410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)  (b) The condition of the physical				

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	<p>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, document review and interview, the hospital created/maintained conditions that could result in a hazard to staff for one of sixteen kitchen work areas and failed to ensure implementation of established policy and procedure (P&amp;P) for storage &amp; unauthorized access of medications in one area (nuclear medicine cardiac room).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. In observation on 8/24/2015 at 12:10 p.m., it was noted that six soda gas cylinders, located in the kitchen's dry storage room, were loosely chained and capable of falling over.</li> <li>2. On 8/24/2015 at 8/24/2015 at 12:10 p.m., staff member #1 acknowledged the above-listed loosely chained soda gas cylinders.</li> <li>3. Review of the P&amp;P titled Pharmacy and Medication Access, indicated Access to the Pharmacy Department or other</li> </ol>	S 1118	<p>S 11181. How are you going to correct the deficiency?1.a. On August 24, 2015 the chain holding the 6 gas cylinders was adjusted to hold the cylinders securely. A gas cylinder cabinet was ordered and on September 23, 2015 was put in place to hold the gas cylinders. The cabinet is metal with a metal mesh latch door. This will eliminate the need to adjust chains.1.b. On September 4, 2015 purchased and put into service a tool box for medications that locks for the Nuclear Medicine Cardiac room medications. The locked tool box will be kept in a cabinet in the locked hot lab. The lock is a combination lock that is known only by our nursing staff. The tool box will be taken to the treadmill room during exams only and will remain in the RN's possession and supervision during test and then will return to the hot lab.2. How are you going to prevent the deficiency from recurring in the future?2.a. Add to monthly safety check list surveillance of gas cylinders to assure in cabinet.2.b. The locked tool box</p>	09/23/2015

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	<p>areas in which medications are stored will be restricted to authorized personnel. The P&amp;P was revised 1/14.</p> <p>4. On 8/24/15 during tour of the facility, between 1:00pm and 2:45pm, in the presence of A2, Manager of Protective Services, and S7, Radiation Clinical Coordinator, the following was observed: just off the public waiting area of the department was an opened door room, indicated to be the Nuclear Medicine Cardiac Room. Inside the room was a rolling cart without a locking device and inside the drawers was medications, including, but not limited to: 2 vials Aminophylline 10ml , 250 mg; 3 Metapropal Tartrate 5mg/5ml; 1 Naloxone HCL 4mg/10ml; Nitrostat 0.4mg/tab, 1/4 bottle; &amp; 2 Dobutamin 1000mg/250ml.</p> <p>5. On 8/24/15 at 2:30pm, S7 indicated the medication cart in the Nuclear Medicine Cardiac Room was the medication cart for the department, that is not locked and did not have a locking device/ability to be locked. S7 indicated that the area is open to visitors when staff is in the back with patients and is open to housekeeping in the evenings when the department is closed. He/she also indicated that both visitors and housekeeping are not authorized to have</p>		<p>will be kept in the locked hot lab when not in use. Only the Radiology Nurses know the combination to unlock the tool box. Only Nuclear Techs and Security will have access to the hot lab when area closed. Staff education occurred regarding change in process. 3. Who is going to be responsible for numbers 1 and 2:3.a. Food and Nutrition Services Manager 3.b. Radiology Manager4. By what date are you going to have the deficiency corrected? 4.a. September 23, 20154.b. September 4, 2015</p>	

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S 1162 Bldg. 00	<p>access to medications.</p> <p>6. On 8/26/15 at 2:00pm, S4, Pharmacy Director, indicated it was the policy of the hospital to keep all medications secured in a locked area secure from unauthorized access and that the medications stored in the unlocked rolling cart in the Nuclear Medicine Cardiac Room did not meet the intent of the policy.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p><b>Based on policy/procedure review and staff interview, the</b></p>	S 1162	Tag S 11621. How are you going to correct the deficiency?1.a. Corrected on August 28, 2015.	08/28/2015

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	<p><b>laboratory failed to document preventative maintenance (PM) of required rotations per minute (rpm) testing for one of three centrifuges, which was used for lipemic patient testing, in accordance between its approved policies and procedures and clinical engineering protocols.</b></p> <p><b>Finding include:</b></p> <p><b>1. The policy, "Clarification of Lipemic Serum and Plasma by Ultracentrifugation", LTR: LTR22090, approved on 7/14/2015, read;</b></p> <p><b>"A lipemic sample can be accurately analyzed when it is first subjected to centrifugation at 90,000 rpm... for 10 minutes in an ultracentrifuge."</b></p> <p><b>6. On 8/25/2015 at 2:15 p.m., staff member #11 acknowledged that rpm documentation for the above-mentioned instrument had not been documented by clinical engineering.</b></p>		<p>Refer to Work Order CE-215913. Clinical Engineering has added a RPM check item to the annual maintenance check that they perform for the Beckman Airfuge centrifuge.2. How are you going to prevent the deficiency from recurring in the future?2.a. Semi-annually the centrifuge will be maintained per Clinical Engineering's Maintenance procedure. The Policy for the Centrifugation of Chemistry Specimens and the Maintenance Procedure for Beckman Airfuge Centrifuge has been updated. Refer to the policy and procedure documents.3. Who is going to be responsible numbers 1 and 2? 3.a. Clinical Engineering and Chemistry Technical Specialist4. By what date are you going to have the deficiency corrected.4.a. August 28, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2015	
NAME OF PROVIDER OR SUPPLIER  COLUMBUS REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E 17TH ST COLUMBUS, IN 47201			
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S 1164  Bldg. 00	<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. Based on document review, observation and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 28 pieces of equipment (1 trapeze bar, 1 set wooden stairs, 1 set parallel bars, 1 rolling walker, 14 standard walkers, 1 trampoline, 1 weight push cart and 4 standard walkers &amp; 4 wheelchairs).</p> <p>Findings:</p> <p>1. Review of the policy/procedure (P&amp;P) titled Preventative Maintenance Completion Rate Calculation, indicated Facilities Engineering Staff is responsible to assure that all Facilities equipment and</p>			S 1164	<p>Tag S 11641. How are you going to correct the deficiency?1.a Revise policy "Routine Service Requirement of Hospital Assets: Preventative Maintenance (PM)". Refer to policy.2. How are you going to prevent the deficiency from recurring in the future?2.a. Review all job plans and complete an inventory of all items falling within the objectives of the policy to determine level of compliance.3. Who is going to be responsible for numbers 1 and 2?3.a. Director Facilities and Materials Management4. By what date are you going to have the deficiency corrected?4.a. September 22, 2015 Revise policy on preventative</p>		02/28/2016

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	<p>systems are routinely maintained. The P&amp;P was last reviewed/ revised 6/14.</p> <p>2. On 8/24/15 between 1pm and 2:45pm, during facility tour, in the presence of A2 Manager of Protective Services and S1, Radiology Manager, the radiology department room CT1, a ceiling mounted pulley type trapeze bar was observed above a computed tomography (CT) scanning table.</p> <p>3. On 8/24/15 between 3pm and 4:45pm, during facility tour, in the presence of A1, Director of Facilities, and A2, just off the elevator in the hall leading to the in-patient rehabilitation unit was a set of free standing wooden therapy stairs. In the rehabilitation physical therapy room was a set of parallel bars, a rolling walker and a storage closet with a minimum of 10 walkers.</p> <p>4. On 8/26/15 during tour of off-site facility K, beginning at 8:30am, the following was observed: 1 trampoline, 1 weight push cart, 4 walkers and 4 wheel chairs.</p> <p>5. Review of preventive maintenance documents lacked evidence of PM for the trapeze bar observed in room CT1, the standard walkers, rolling walker, therapy stairs, or parallel bars observed in the</p>		<p>maintenance approach and routine service work4.b September 30, 2015 Policy revision to the Safety Committee 4.c November 30, 2015 Education to all staff on revised policy4.d November 30, 2015 Job Plan revision for safety review4.e. December 30, 2015 Job Plan revisions for function and general care4.f. January 30, 2016 Job Plan revisions for Industry Standards and Regulatory Requirements4.g. February 28, 2016 Job Plan revisions for Manufacturer Recommendations</p>		

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	<p>in-patient rehabilitation department, wheelchairs, walkers, trampoline or weight push cart observed at off-site K.</p> <p>6. On 8/24/15 at 3:30pm, A1 indicated the hospital does not provide PM per an automated equipment management (AEM) program, but instead, follows manufacturer recommendations and if none exists, then sets a PM schedule together with the safety program.</p> <p>7. On 8/26/15 at 1:00pm, A1 confirmed the hospital lacked evidence of PM for the trapeze bar, the set wooden stairs, the parallel bars, the rolling walker, the 14 standard walkers, the trampoline, the weight push cart, the 4 standard walkers and the 4 wheelchairs.</p>			