

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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
--------------------	--	---------------	---	----------------------

S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 7/29/2014 through 7/31/2014</p> <p>Facility Number: 003312</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/11/14</p>	S000000		
S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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>which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation and staff interview, the hospital failed to ensure hand washing facilities were located in the internal laundry room.</p> <p>Findings included:</p> <p>1. At 12:16 PM on 7/30/2014, the Environmental Service's Laundry room was inspected. The room was observed with two industrial units: 1 washer, 1 dryer. The room was observed with 5-gallon containers of chemicals that were observed injecting chemicals into the industrial washer. The industrial dryer was observed with assorted mop heads within the dryer tumbler. The room was observed without any hand washing facilities to utilize between handling of soiled mop heads and clean mop heads.</p>	S000608	<p>· <b>Short Term Remedy:</b> Hand sanitizer holder replaced and sanitizer container installed __ · <b>Date Started:</b> 30 July 2014 · <b>Date to be Completed:</b> 30 July 2014 · <b>Long Term Remedy:</b> _Linen staff informed and encouraged to use the CALL ONE work order system to report broken items the areas of work. Hand sanitizer replacement is a priority repair item. __ · <b>Date Started:</b> 30 July 2014 · <b>Date to be Completed:</b> 30 July 2014 · <b>Plan to prevent future recurrence:</b> Inspect for broken hand sanitizer stations on Safety and Security safety rounds. · <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Heart Hospital Materials Management Site Manager · <b>What date will deficiency be corrected?</b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.)30 July 2014</p>	08/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/31/2014	
NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250			
(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			
S000612	<p>2. At 12:20 PM on 7/30/2014, Environmental Service staff member #10 indicated the washer and dryer are used to wash assorted mop heads. The staff member confirmed the laundry room does not have either a hand washing sink or hand sanitizer.</p> <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: (xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation and staff interview, the hospital failed to</p>	S000612	<p><b>Short Term Remedy:</b>  Cubicle curtains moved to a clean</p>	09/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE			STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250		
(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>store clean drapes/curtains in a sanitary environment.</p> <p>Findings included:</p> <p>1. At 12:40 PM on 7/30/2014, the main Environmental Service's storage room was observed storing clean drapes/curtains on a clothes rod. The room was observed with blown-on insulation on the ceiling, scrubber batteries being charged, storing assorted chemicals and janitorial supplies, etc. The room was an unsanitary, dirty room storing clean drapes/curtains for patient rooms.</p> <p>2. At 12:50 PM on 7/30/2014, Environmental Service staff member #10 indicated the main housekeeping room was a dirty room; however, he/she does not have any other place to store the clean drapes/curtains.</p>		<p>area at companion hospital on north campus (Community Hospital North). As need arises, curtains will be obtained from companion hospital.</p> <p>-</p> <p>-</p> <p>· <u>Date Started:</u> 7/30/14</p> <p>· <u>Date to be Completed:</u> 7/31/14</p> <p>-</p> <p>· <u>Long Term</u></p> <p><u>Remedy:</u></p> <p>-</p> <p>Will store the bulk of our cubicle curtains across the street at our North location to retrieve for larger projects however approximately 4 or 5 curtains will be stored in a covered tote in the paper storage area of Heart and Vascular Hospital. EVS has ordered storage tote with lid, awaiting delivery.</p> <p>-</p> <p>-</p> <p>· <u>Date Started:</u> August 1st</p> <p>· <u>Date to be Completed:</u> September 1st</p> <p>-</p> <p>· <u>Plan to prevent future recurrence:</u></p> <p>EVS management will monitor storage areas and ensure that tote has adequate number of curtains and lid is kept closed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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
S001028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure all medications were secured while storing them in the Infectious Waste Room.</p>	S001028	<p>· <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) <b>EVS Site Manager at Heart</b></p> <p>· <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.) <b>8/29/2014</b></p> <p>· <b><u>Issue Identified:</u></b></p> <p>Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>O At 12:45 PM on 7/30/2014, the Infectious Waste Room was toured</p>	11/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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><b>Findings included:</b></p> <p>1. At 12:45 PM on 7/30/2014, the Infectious Waste Room was toured on the Receiving Dock; out of sight from health care practitioners or pharmacy personnel. The room contained biohazard containers toward the rear of the room. In the front of the room were ten 13-gallon blue-top plastic containers and 15 black containers with assorted pharmaceutical supplies and medications that were to be disposed of by a contracted service. Environmental staff member #41 was observed entering the Infectious Waste Room. The staff member was observed opening the blue-top pharmaceutical waste within a few seconds. The blue-top containers were not secured when in storage from unauthorized personnel.</p> <p>2. At 10:45 AM on 7/31/2014, pharmacy staff member #38 indicated the discarded medication stored in the Infectious Waste</p>		<p>on the Receiving Dock; out of sight from health care practitioners or pharmacy personnel. The room contained biohazard containers toward the rear of the room. In the front of the room were ten 13-gallon blue-top plastic containers and 15 black containers with assorted pharmaceutical supplies and medications that were to be disposed of by a contracted service. Environmental staff member #41 was observed entering the Infectious Waste Room. The staff member was observed opening the blue-top pharmaceutical waste within a few seconds. The blue-top containers were not secured when in storage from unauthorized personnel.</p> <p>o IDR submitted and notice of denial received on 10/20/2014.</p> <p>-</p> <p>· <b><u>Short Term Remedy:</u></b></p> <p>o See long term remedy.</p> <p>-</p> <p>· <b><u>Date Started:</u></b></p> <p>· <b><u>Date to be Completed:</u></b></p> <p>-</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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
	Room for pick-up should be secured at all times from unauthorized personnel. The housekeeping staff are not authorized personnel that have access to any medications. The staff member confirmed the medication in the Infectious Waste Room for disposal was not secured from unauthorized personnel.		<p><b>Long Term Remedy:</b></p> <p>Non-hazardous medication waste containers used at Community Health Network do not have permanent sealing lids. To prevent diversion, tamper evident tape will be applied to full containers BEFORE transport to the central accumulation area. Once the container is sealed with tamper evident tape, it will be initialed and dated on both the tape and the container.</p> <p>Full sealed containers are then brought to the central accumulation area. The Central Accumulation will be audited at least weekly until 100% compliance is reached for 3 consecutive months, to ensure proper storage requirements are being met and the tamper evident seal is intact.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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>If the tamper evident tape is broken, Security will be notified and an incident report will be completed.</p> <p>-</p> <p>· <b><u>Date Started:</u></b> October 21st, 2014</p> <p>· <b><u>Date to be Completed:</u></b> November 14th, 2014</p> <p>-</p> <p>· <b><u>Plan to prevent future recurrence:</u></b></p> <p>Tamper evident tape will be applied to containers. The containers will be audited in the Central Accumulation area, at least weekly until 100% compliance is reached for 3 consecutive months, to ensure they are sealed properly and without evidence of tampering.</p> <p><b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) CHVH – Pharmacy Manager</p> <p>CHVH – Director of Environmental Services</p> <p>· <b><u>What date will deficiency be</u></b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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
S001118	<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 documentation review, observation, and staff interview, the hospital 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 two (2) instances: Maintenance Department, Medical Gas Storage.</p> <p>Findings included:</p> <p>1. Safety Security</p>	S001118	<p><u>corrected?</u> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)<b>11-14-14</b></p> <p>1) · <b>Short Term Remedy:</b> Buckets removed immediately · <b>Date Started:</b> 30 July 2014 · <b>Date to be Completed:</b> 30 July 2014 · <b>Long Term Remedy:</b> · Facility staff instructed that the eye wash stations are essential for the prevention of injury caused by chemicals used in the area of the stations. The buckets were removed from the mechanical spaces. All facility staff members made to understand buckets under the shower heads will not be tolerated. · <b>Date Started:</b> 30 July 2014 · <b>Date to be Completed:</b> 4 August 2014 · <b>Plan to prevent future recurrence:</b> All facility staff members have been alerted to the bucket under the emergency</p>	08/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
--	---

(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/Procedure; Title: Eye Wash Station Requirements (Last approved 12/2011) stated, "Area around eye wash must be free of any obstructions. Flow of water must be clear."</p> <p>2. At 12:04 PM on 7/30/2014, the Maintenance Department was toured. Two of two eye wash/shower combos were observed with a 5-gallon bucket hanging from the shower head. one of the buckets was observed half filled with water. The buckets were obstructing the flow of water in case of immediate use.</p> <p>3. Safety Manual policy (Last approved 5/2014) stated, "Gas cylinders are properly secured."</p> <p>3. At 12:35 PM on 7/30/2014, the Medical Gas Storage room was observed with 5 filled Nitrous Oxide tanks unsecured. The chain for securing the tanks was observed lying on the floor.</p>		<p>shower head issue and will watch to ensure no future occurrence.</p> <p>· <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Facility Director CHN and CHVH ·</p> <p><b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)4 August 2014 2)· <b>Short Term Remedy:</b> Tanks secured on day of inspection __ · <b>Date Started: 30 July 2014</b> · <b>Date to be Completed:</b> 30 July 2014 ·</p> <p><b>Long Term Remedy:</b> _Dock staff must ensure all gas cylinders are secured _ · <b>Date Started:</b> 30 July 2014 · <b>Date to be Completed:</b> 30 July 2014 ·</p> <p><b>Plan to prevent future recurrence:</b> Checks completed with Safety and Security safety rounds · <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Manager of North and Heart Hospital Material services ·</p> <p><b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)· Deficiency cleared at time of inspection.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE			STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250		
(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	
	4. At 9:30 AM on 7/31/2014, Maintenance staff member #32 indicated the two shower heads of the eye wash station shower combos were obstructed with the bucket hanging from the shower head. The staff know the procedures for keeping the eye wash stations clear of obstruction. The staff member confirmed the nitrous oxide cylinders were unsecured; they were new and ready for use.				