

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151310	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER WABASH COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 7/21/2014 through 7/22/2014</p> <p>Facility Number: 005094</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 08/04/14</p>	S000000		
S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to</p>	S000554	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction. · Policy</p>	07/22/2014

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

TITLE

(X6) DATE

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

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	<p>ensure clean supplies and equipment were protected from contamination in the Materials Management Department.</p> <p>Findings included:</p> <p>1. During the tour of the Materials Management Department at 1:45 PM on 7/21/2014, accompanied by staff members #5 and #13, several cardboard shipping boxes of supplies were observed stored in the clean supply room, alongside unprotected clean equipment and supplies on wire storage shelves. The shipping boxes were also stored above unprotected clean equipment and supplies on wire storage shelving units. The shipping boxes evidenced shipping labels. Several shipping boxes were also utilized as storage containers with the tops cut off exposing the clean equipment and supplies.</p> <p>2. At 1:55 PM on 7/21/2014, staff member #13 confirmed some of the</p>		<p>#955.1.16, Storage of Patient Care Supplies and Equipment, will be implemented. Large items will be cohorted in the General Storage area on the perimeter of the Materials Management storage area, which is not considered to be a clean storage area. Items in the General Storage area may remain in outside shipping materials. Small/Individual patient care items will be unpackaged from the outer shipping boxes and placed in the "Clean Storage" area of the Materials department on the wire shelving/racks. Small items may need to be placed in storage containers to organize/contain them on the shelves, but shall not remain in outer shipping boxes. 2. How are you going to prevent the deficiency from recurring in the future? · To continue compliance, Materials Management will complete a "spot check" monthly and report compliance to the Performance Improvement Committee. 3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc. · The Materials Management Leader is ultimately responsible for the corrective action and for overall and ongoing compliance. 4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed</p>	

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S000596	<p>boxes arrived directly to the room from the outside and were not boxes removed from an outer wrap.</p> <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 documentation review, and staff interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations.</p> <p>Findings included:</p>	S000596	<p>is 30 days from the date of the survey. Materials Management rearranged storage areas on 7/22/14. The policy will be approved by the Medical Staff Quality Committee on August 20, 2014, the Medical Executive Committee on September 8th, 2014, and the Board on September 16th, 2014.</p> <p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>Revised policy #2000.1.33, Cidex OPA, to state that staff shall manually rinse thoroughly the device by emerging it completely in 2 gallons on water 3 times. Each time should be done for a minimum of one minute. Always use fresh</p>	10/01/2014

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	<p>1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices. Cidex OPA manufacturer sheet requires: 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.</p> <p>2. At 12:20 PM on 7/21/2014, staff member #6 explained the procedure of rinsing ultrasound probes that had Cidex OPA on them. The staff member takes the probes to the Ultrasound room restroom's handwashing sink and runs water on the probe for one minute. The staff member read the Cidex OPA rinsing procedure and confirmed the Radiology Department staff do not follow the Cidex OPA's rinsing procedures.</p>		<p>water each time this step is done.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> Radiology Department does not have the physical environment to practice current standards. All instruments will be brought to central sterile for proper cleaning effective immediately. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> The Radiology Department Leader is ultimately responsible for the corrective action and for overall and ongoing compliance. <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. Staff will review the policy within 15 days of it being finalized by Medical Staff Quality on August 20, 2014, Medical Executive Committee on September 8th, 2014, and the Board on September 16th, 2014.</p>				

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S000598	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on observation and staff interview, the facility failed to ensure the Radiology Department was complying with FDA requirements on not refilling ultrasound gel containers.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have</p>	S000598	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · Facility-wide policy #2000.1.34, Ultrasound gel containers, ban on refilling of, will be implemented. Materials Management will begin purchasing 8oz bottles of ultrasound gel. Staff will throw the bottles away when empty. "Do NOT Refill" labels will be placed on all ultrasound gel bottles throughout the organization. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · To continue compliance, the Radiology Department will monitor disposal of ultrasound bottles monthly for six months and will 	10/01/2014
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	<p>antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that ultrasound gel containers not to be refilled.</p> <p>2. At 12:20 PM on 7/21/2014, the Radiology Department Ultrasound Room was inspected. Located in the room was a counter with 16-ounce ultrasound gel containers and on the counter was a partial bulk plastic container of Aquasonic Ultrasound Gel. On the counter top was an Aquasonic Gel thermal sonic warming unit with plastic bottles warming in the unit.</p> <p>3. At 12:25 PM on 7/21/2014, staff member #6 indicated he/she refills the ultrasound gel plastic bottles. The staff member indicated a box containing 2 empty plastic bottles and a bulk plastic container of Aquasonic Ultrasound Gel would be delivered to the</p>		<p>report compliance to the Performance Improvement Committee.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc. · The Radiology Department Leader is ultimately responsible for the corrective action and for overall and ongoing compliance.</p> <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. Staff will review the new policy within 15 days of it being finalized by Medical Staff Quality on August 20, 2014, Medical Executive Committee on September 8th, 2014, and the Board on September 16th, 2014.</p>	

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S000608	<p>department from the manufacturer. The two empty plastic containers would be refilled several times with the bulk container of ultrasound gel until it was empty.</p> <p>4. At 1:30 PM on 7/21/2014, staff member #15 indicated the ultrasound gel bottles are sent back to the Radiology Department for them to be refilled.</p> <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 which are pertinent to infection control. These include, but are not limited to, the following:</p>			

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	<p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks and nail polish.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the perioperative area at 1:00 PM on 07/21/14, accompanied by staff member A2, three different staff members were observed walking through the hallways with surgical masks hanging around their necks. During the tour of the sterile processing and decontamination areas at 1:25 PM on 07/21/14, accompanied by staff member A2, a certified surgical tech, staff member A19, was observed wearing bright nail polish with many chipped areas. The facility policy "Dress Code in Surgery", last revised 07/13, indicated, "III. All nail polish, rings, watches or bracelets must be removed before scrubbing. ...IV. All persons entering the restricted area of the surgical suite should wear masks. ...b. Masks should be 	S000608	<ol style="list-style-type: none"> How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction. <ul style="list-style-type: none"> Surgery staff will review the revised hospital policy regarding surgical attire, #660.2.03, that contains stronger language regarding proper surgical mask wear, replacement, and discarding. Policy #660.2.03 was also revised to contain stronger language regarding nail polish (lack of). How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> All staff will review the updated policy and document/sign that they have done so. Surgery staff will also complete AORN's Recommended Practices for Surgical Attire as well as complete the post practices quiz. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc. <ul style="list-style-type: none"> The Surgery Department Leader is ultimately responsible for the corrective action and for overall and ongoing compliance. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. 	08/28/2014			

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S000612	<p>removed and discarded after use. It should be changed and a clean one worn for each case. i. They are not to be saved by hanging around the neck or tucking into a pocket for future use. ...Reference used: AORN Standards."</p> <p>4. At 1:10 PM on 07/21/14, staff member A18, a nurse in the surgical area, indicated nail polish was not permitted for staff working in the OR (Operating Room).</p> <p>5. At 1:25 PM on 07/21/14, the surgical tech, staff member A19, indicated sometimes she worked in the instrument room, but today he/she was scrubbing in the OR.</p> <p>6. At 1:45 PM on 07/21/14, staff member A2 confirmed the facility followed AORN (Association of periOperative Registered Nurses) guidelines.</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</p>		<p>Surgery staff will review the updated policy and AORN's Recommended Practices for Surgical Attire, and complete the quiz by 8/28/14. The policy will be approved by the Medical Staff Quality Committee on August 20, 2014, Medical Executive Committee on September 8th, 2014, and the Board on September 16th, 2014.</p>				

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	<p>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. Based on observation and staff interview, the hospital failed to ensure proper handling of hospital drapes and curtains.</p> <p>Findings included:</p> <p>1. General Hospital AIA Guidelines indicate arrangement of equipment that will permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations. A separate room for receiving and holding soiled linen until ready for pickup or processing.</p> <p>2. At 11:15 on 7/21/2014, the Main Soiled Linen Storage Room was observed with a washer and dryer. Soiled utility carts were observed on both sides of the room with the washer/dryer set up at the</p>	S000612	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · The washer and Dryer will be relocated to another room, outside of the soiled linen area. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · To continue compliance, the linen cleaning process will be monitored monthly to verify staff is covering clean linen in transport. This will be monitored for six months and reported to the Performance Improvement Committee. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> · The Facility Services Department Leader is ultimately responsible for the corrective action and for overall and ongoing compliance. <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days</p>	08/29/2014

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S000912	<p>far end. To get to the washer/dryer set up, a person must walk past the soiled linen carts.</p> <p>3. At 2:22 PM on 7/21/2014, staff member #5 confirmed the hospital dirty linen was stored in the same room where the hospital curtains/drapes are washed and dried.</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>		<p>from the date of the survey. Washer and dryer will be moved to the new location by 8/29/14.</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 policy and procedure review, medical record review, and interview, the nurse executive failed to ensure pain assessments were done according to policy and protocol for 4 of 10 patients seen in the Emergency Department (ED) (N1, N4, N5, and N15).</p> <p>Findings included:</p> <p>1. The facility policy "Pain Management", last reviewed 01/10/14, indicated, "At time of admission to the facility or initial visit to outpatient care area, the patient will be assessed during the initial nursing assessment. The patient will be asked to describe or 'rate' their pain using the 'Numeric' scale of pain. i.e., the patient will be asked to describe their pain on a 0-10 scale. ...If unable to respond to questions regarding pain intensity using the 'Numeric' scale, the nurse will assess the intensity of pain using another appropriate scale for rating pain. ...Approved scales for assessment of pain at Wabash County Hospital are:</p>	S000912	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> Emergency and Med/Surg staff will review the current pain management policy and sign that they have done so. Emergency and Med/Surg Departments will include pain management in their performance improvement plans. Charts will be reviewed for compliance and will be reported to the Performance Improvement Committee. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> To continue compliance, leaders will review charts periodically as well as develop a Performance Improvement Plan to include pain management. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> The Emergency and Med/Surg Department Leaders are ultimately responsible for the corrective action and for overall and 	08/15/2014

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	<p>1. Numeric scale ...2. Face scale ...3. Infant/Child Pain Assessment Tool."</p> <p>2. The medical record for patient N1, a 7-year old seen in the ED on 5/25/14 for mid-back pain, indicated "10 See Notes" circled in the pain rating area, but lacked further documentation describing the pain in the notes.</p> <p>3. The medical record for patient N4, a 36-year old seen in the ED on 5/23/14 for migraine and small lump under the arm, lacked any documentation regarding a pain assessment.</p> <p>4. The medical record for patient N5, a 77-year old seen in the ED on 5/23/14 for a catheter change and a possible UTI (urinary tract infection), lacked any documentation regarding a pain assessment.</p> <p>5. The medical record for patient N15, a 6-year old seen in the ED on 5/02/14 for a cough and fever, indicated "See Notes" circled in the pain rating area, but lacked further documentation describing the pain in the notes.</p> <p>6. At 9:20 AM on 07/22/14, staff member A2, who assisted with the medical record review, confirmed the pain assessments were not documented</p>		<p>ongoing compliance.</p> <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. Performance Improvement Plans were completed 8/15/14. Periodic chart reviews will be completed monthly. Review of compliance will be completed in 6 months by the Performance Improvement Committee.</p>		

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S001014	<p>according to policy.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to follow its pharmacy policy regarding multidose medications.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 1:30 PM on 07/21/14, accompanied by staff members A2 and A18, an open, but not dated vial of Labetalol and a vial of Bloxiverz, with an open date of 5/01/14, were observed in the top drawer of the anesthesia cart in OR (Operating Room) 2.</p> <p>2. At 1:35 PM on 07/21/14, staff member A18 indicated pharmacy would exchange the drug tray at the end of each day, but the open vials observed were in the drawer, not in the drug tray.</p>	S001014	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> Anesthesia cart check will be completed by Surgery staff daily and by Pharmacy staff monthly. Surgery staff will log checks daily. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> The Surgery RN who exchanges the surgery trays will, upon removal of the tray from the cart, check each drawer of the cart for any medication vials misplaced outside the surgery trays. The pharmacy technician will also check each cart for medication during the monthly quality assurance check and report to the pharmacy leader any findings. Policy #7730.1.01, item 11, will be reviewed with entire nursing staff by WCH staff educator by 08/31/2014. A small poster was 	08/31/2014

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	<p>3. During the tour of the Medical/Surgical Unit at 2:00 PM on 07/21/14, accompanied by staff members A2 and A20, an open Novolog Flex Pen (insulin), labeled for a patient, was observed in the medication room. A label on the insulin pen indicated the pen was opened on 07/21/14 and should be discarded on 10/21/14, 90 days later. Staff member A20 confirmed that the insulin pen was labeled correctly.</p> <p>4. The facility policy "Drug Distribution", last revised 09/12, indicated, "11. Injectable Medications: All injectables (except insulin) should be treated as single dose vials unless indicated by pharmacy when single dose vials are unavailable. Multiple dose vials must be marked with an expiration date of 28 days (or less is required by manufacturer) upon initial access."</p> <p>5. At 9:15 AM on 07/22/14, the pharmacist, staff member A14, indicated all multi-dose vials should be dated when opened and discarded after 28 days. He/she indicated this also applied to all insulin pens except Levemir, which was good for 42 days. He/she indicated he/she did not know why the open vials of medication were in the anesthesia cart.</p>		<p>posted on 7/25/14 in each automated drug cabinet (Pyxis) area reminding the nursing staff that there is a 28 day limit on open vials of medication. The nurse who labeled the insulin pen with a 90 day expiration date was re-educated on 7/22/2014 to the proper labeling of multi-dose expiration for injectable medications. The pharmacy technicians will check the insulin pens and any other medication vial assigned to an individual patient for appropriate labeling during daily Pyxis fill.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc. The Pharmacy and Surgery Department Leaders are ultimately responsible for the corrective action and for overall and ongoing compliance. The Staff Educator will assure staff is educated on policy #7730.1.01, Drug Distribution.</p> <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. All staff will be educated on the policy by 08/31/14.</p>				

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S001022	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</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>(B) Appropriate storage conditions.</p> <p>Based on observation, documentation review, and staff interview, the hospital failed to ensure there was a pharmaceutical policy on storing Radiology Sodium Chloride Injection and a contrast media in a contrast media warmer.</p> <p>Findings included:</p> <p>1. At 1:02 PM on 7/21/2014, the Cat Scan Room was observed with a contrast media warmer on a counter. The warmer contained 14 cartons of 75 ml Optiray 320 contrast media and 8 cartons of 125 ml Sodium Chloride injections and each cart was dated. The</p>	S001022	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> The contrast media warmer was removed from the Radiology Department on 8/7/14. Optiray 320 and Sodium Chloride cartons were stored in a locked cabinet on 8/7/14 at CRT (controlled room temperature 59-86 degrees F). <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> To continue compliance, a pharmacy technician will include the Cat Scan Room in the monthly quality assurance checks starting in August of 2014 to make sure that appropriate storage conditions are being met on an ongoing basis. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> The Pharmacy and Radiology Department Leaders are ultimately 	08/07/2014
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	<p>warmer had a temperature tape on the inside indicating 102 degrees Fahrenheit. The warming cabinet did not have any temperature log with the unit.</p> <p>2. Sodium Chloride Injection 125 ml carton insert noted to store at 59 to 86 degrees Fahrenheit. The insert does not note that the carton can be stored in a warmer.</p> <p>3. Optiray 320 Ioversol injection (Organically Bound Iodine) indicated to store at 59 to 86 degrees Fahrenheit. However, the product may be stored up to 104 degrees Fahrenheit not to exceed 30 days.</p> <p>4. At 3:10 PM on 7/21/2014, staff members #5 and #6 indicated the hospital does not have a policy on storing contrast media and Sodium Chloride in a warmer. The staff confirmed the Radiology Department was not maintaining a temperature log of the contrast media warmer.</p>		<p>responsible for the corrective action and for overall and ongoing compliance.</p> <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. The issue identified was corrected on 8/7/14. Pharmacy and Radiology staff was educated on 8/7/14.</p>		

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S001118	<p>5. At 2:15 PM on 7/22/2014, staff member #14 indicated the same manufacturer produces both 75 ml Optiray 320 contrast media and 125 ml Sodium Chloride injections. The manufacturer has it in writing that the contrast media can be stored in a warmer; however, the manufacturer does not have it in writing that the sodium chloride can be warmed. The staff member indicated the hospital should have a policy on how to store both items and to require staff to record the temperature of the contrast media warmer.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a</p>						

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	<p>hazard to patients, public, or employees.</p> <p>Based on observation, facility document review, policy and procedure review, manufacturer's guidelines 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: Emergency Department, Med/Surg Departments, Maintenance Department and PACU (post anesthesia care unit).</p> <p>Findings included:</p> <p>1. Because 1910.178 does not have a 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</p>	S001118	<p>Eyewash Stations:</p> <p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> An eyewash station was installed in both the ED soiled room and the Med/Surg soiled room on 8/15/14. An eyewash station will be installed in the Generator room by 8/22/14. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> The ED, Med/Surg, and Facility Services Departments will continually monitor and document testing according to policy #1000.1.38, Eyewash Stations. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> The Maintenance, Emergency, Med/Surg, and Surgery Department Leaders are ultimately responsible for the corrective action and for overall and ongoing compliance. <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey.</p> <ul style="list-style-type: none"> Eyewash stations were installed on 8/15/14 in both the ED and Med/Surg. An eyewash station will be installed in the Generator 	08/22/2014

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	<p>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>2. At 12:35 PM on 7/21/2014, the Emergency Department was toured with staff members #2 and #16. An enzymatic cleaner was observed used to soak instruments in the Soiled Utility Room. Staff member #17 was observed mixing 1 pump of cleaner with basin of water. The Soiled Utility Room did not have an eye wash station nor did the department have an eye wash station.</p> <p>3. At 1:00 PM on 7/21/2014, the Med/Surg Department soiled utility room was toured with staff member #2. Staff member #20 was observed using an enzymatic</p>		<p>room on 8/22/14. Warming Cabinets:</p> <p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> Policy #1000.1.64, Warming Cabinets, will be implemented. Emergency, Med/Surg, and Surgery Department staff will review the new warming cabinet policy and sign that they have done so once the policy has been approved by Quality Committee, Medical Executive Committee and the Board. The staff will check/clean cabinets according to the new policy. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> Staff that has a warming cabinet will review/read the new policy and sign/document that they have done so. Leaders within these departments will review monthly that temperatures are taken daily. This will also be included in the departmental Performance Improvement program. <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.</p> <ul style="list-style-type: none"> The Emergency, Med/Surg, and Surgery Department Leaders are ultimately responsible for the corrective action and for overall and ongoing compliance. <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month,</p>		

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	<p>cleaner to clean instruments in the soiled utility room. The room had no eye wash station.</p> <p>4. The enzymatic cleaner's product label used in the Emergency Department and Med/Surg Department Soiled Utility Rooms indicated 15 minutes of flushing of the eyes if the product comes in contact with someone's eyes.</p> <p>5. At 2:00 PM on 7/21/2014, the diesel generator was inspected in the Maintenance Department Mechanical Room with staff member #5. An industrial external battery was connected to the generator while a battery charge was connected to the battery. The room or the room adjacent to the Mechanical Room did not have an eye wash station for emergency use if acid from the batteries come in contact with a person's eyes.</p> <p>6. At 2:15 PM on 7/21/2014, staff member #5 indicated the maintenance staff conduct weekly</p>		<p>day and year). The maximum correction time allowed is 30 days from the date of the survey.</p> <p>The staff will review the new policy within 15 days of it being finalized by Medical Staff Quality – August 20, 2014, Medical Executive Committee – September 8th, 2014 and Board – September 16th, 2014.</p>		

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	<p>generator battery inspections.</p> <p>7. During the tour of the ED (emergency department) at 12:05 PM on 07/21/14, accompanied by staff members A2 and A16, a small Pedigo warming unit containing blankets and registering 168 degrees F. (Fahrenheit) was observed in the overflow area. The temperature monitoring log on the unit for July 2014 indicated "see manufacturer's guide for correct temperature range". The log indicated documentation for 7 of the first 21 days of the month with a temperature range of 138 to 172 degrees F.</p> <p>8. At 12:10 PM on 07/21/14, staff member A16 indicated the night shift staff should document the temperature daily, but he/she was not aware of what the acceptable range was.</p> <p>9. During the tour of the PACU (post-anesthesia care unit) at 1:10 PM on 07/21/14, accompanied by</p>			

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	<p>staff members A2 and A18, a small Steris warming unit containing blankets was observed registering 130 degrees F.</p> <p>10. At 1:15 PM on 07/21/14, staff member A18 indicated he/she thought the warming unit had an internal regulating device and indicated the staff did not document any monitoring of the temperature.</p> <p>11. Review of the "Blanket Warmer Temperature Tracking Form" from the Pedigo warmer in the ED indicated only 3 checks for June 2014, documented as 150, 158, and 140 degrees F., and 13 checks for May 2014, ranging from 120 to 170 degrees F.</p> <p>12. The only facility policy regarding warmers, provided by facility staff, was titled "Blood, Fluid Warmer", initiated 10/12, and concerned "Warming of irrigation solutions in plastic pour bottles". The policy only discussed</p>						

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	<p>a temperature for warming the irrigation solutions.</p> <p>13. The manufacturer's manual for the Pedigo Warming Cabinet indicated the electronic control had an adjustable temperature range of 98 to 200 degrees F., but did not recommend any specific temperature range for blanket warming.</p> <p>14. The manufacturer's manual for the Steris Warming Cabinet indicated the electronic control had an adjustable temperature range of 90 to 160 degrees F., but did not recommend any specific temperature range for blanket warming. The manual indicated an overtemperature alarm would alarm for a temperature greater than 10 degrees above the set temperature.</p> <p>15. At 10:00 AM on 07/22/14, staff member A2 confirmed the facility followed AORN guidelines which recommended a blanket</p>						

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S001164	<p>warmer should not be over 130 degrees F. and should be monitored regularly.</p> <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 documentation review, observation, and staff interview, the hospital failed to provide evidence of preventive maintenance on in-patient rehab steps and contracted service sleep study machine.</p> <p>Findings included:</p> <p>1. The preventive maintenance inspections were reviewed; the documentation could not evidence that the in-patient rehab steps or</p>	S001164	<p>1. How do you plan to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> · To provide continuous monitoring, WCH will assure preventive maintenance on equipment located in the sleep lab and on the wooden rehab steps is completed annually. WCH will also establish a weight limit on the wooden rehab steps. <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> · To continue compliance, APRN will provide documented equipment maintenance records to the Facility Services department on 	08/22/2014

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NAME OF PROVIDER OR SUPPLIER WABASH COUNTY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992			
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	<p>the contracted service sleep machine had a preventive maintenance inspection.</p> <p>2. The sleep service agreement with Wabash County Hospital indicated the sleep service will make available to the hospital preventive maintenance on the equipment utilized in the sleep center.</p> <p>3. At 11:20 AM on 7/21/2014, the In-patient Rehab Department was toured. The wooden rehab step handrails were loose when handled. The steps did not have evidence of a preventive maintenance inspection tag or sticker on them.</p> <p>4. At 11:25 AM on 7/21/2014, staff member #5 indicated the in-patient rehab steps have never been evaluated for a weight limit. The steps were built at the hospital. The staff member indicated a preventive maintenance inspection has never been conducted on the</p>		<p>an annual basis. Facility Services staff will complete preventive maintenance on the wooden rehab steps and will verify equipment meets established weight limits, and label as such, on an annual basis.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc. The Facility Services Leader is ultimately responsible for the corrective action and for overall and ongoing compliance.</p> <p>4. By what date are you going to have the deficiency corrected? You must provide a specific date (month, day and year). The maximum correction time allowed is 30 days from the date of the survey. Preventive maintenance was completed on the sleep study machine on 7/29/14. Preventive maintenance was completed on the wooden rehab steps on 8/12/14. Preventive maintenance will be completed on an annual basis. A weight limit on the wooden rehab steps will be established by 8/22/14.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151310	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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	in-patient rehab steps. The staff member indicated the sleep service could not provide evidence to the hospital on preventive maintenance of the sleep study machines when requested.			