

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN ST CLINTON, IN 47842		
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/4/2013 through 9/5/2013</p> <p>Facility Number: 005055</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 09/13/13</p>	S000000			

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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S000406	<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 dental services, laundry services, MRI services and security services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Union Hospital Clinton Quality Improvement Plan policy #114 (last reviewed February 2013) implements all service with direct or indirect impact on patient care quality shall be reviewed under</p>	S000406	<p>1. Quality Management met with each respective department identified in this deficiency and discussed quality assessment monitoring and reporting. Each area in coordination with Quality Management has selected quality assessment and improvement indicators with defined goals. These quality assessment and monitoring items along with ongoing reporting schedule were taken to the Committee of the Whole (COW) on September 24, 2013 in which they were approved by the members in attendance. Data collection to begin immediately with initial reporting to begin with the respective October 2013 meeting schedule. (See Attachments 1-4: COW Agenda, Quality Monitoring Plan, COW minutes and COW Reporting Agenda). 2. During the annual comprehensive quality</p>	10/22/2013			

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	<p>the quality improvement program.</p> <p>2. The selected 4 services (dental services, laundry services, MRI services and security services) were not identified as being evaluated and monitored through the facility's comprehensive quality assessment and improvement program.</p> <p>3. At 9/5/2013 at 1:00 PM, staff member #6 confirmed dental services, laundry services, MRI services and security services were not identified as part of the facility's comprehensive quality assessment and improvement (QA&I) program.</p>		<p>assessment and improvement program review an accounting of all services with direct or indirect impact on patient care quality will be reviewed to ensure reporting is captured for all applicable areas. 3. The assigned Quality Specialist at Union Hospital Clinton in coordination with the System Manager and VP of Quality will provide oversight. 4. Completion date October 22, 2013</p>		

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S000596	<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 document review, observation, and interview, the facility failed to ensure chemical MetriCide OPA was used according to the manufacturer's recommendations and per policies for the Radiology Department.</p> <p>Findings included:</p> <p>1. MetriCide OPA Plus manufacturer sheet requires: 1) Thoroughly rinse the semi-critical medical device by immersing it completely in a large volume (e.g. 9 liters) of water. Use sterile</p>	S000596	<p>1. The Ortho-Phthaldehyde OPA for High-Level Disinfection policy was revised according to the manufacturer's recommendations and was presented to Infection Control Committee for approval on September 12, 2013. Those committee members in attendance approved the revised policy as submitted. (See Attachment 1-3: Infection Control Agenda, Infection Control minutes and Updated Ortho-Phthaldehyde OPA for High-Level Disinfection Policy). Installation of a new three-bay sink in the Radiology Department was completed on September 27, 2013. This sink will be used to totally submerge equipment in the recommended large volume of water for each of the three rinses. (See Attachment</p>	09/30/2013			

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	<p>water unless potable water is acceptable. 2) Keep the device totally immersed for a minimum of 1 minute in duration. 3) Manually flush all lumens with large volumes (not less than 100 ml) of rinse water. 4) Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing of any other purpose. 5) Repeat the procedure 2 additional times for a total of 3 rinses. The manufacturer does not recommended PCI ventilated hood system for soaking and rinsing semi-critical devices.</p> <p>2. At 2:30 PM on 9/4/2013, the Ultrasound room in the Radiology Department was toured. The vaginal probes were observed soaking in a wall-mounted PCI ventilated hood system that containered a 32-ounce water container.</p> <p>3. At 2:40 PM on 9/4/2013, staff member #14 indicated the rinsing</p>		<p>4-5: Pictures of Three-Bay sink installed in Radiology Department and Specification Sheet). Education regarding the change in practice for rinsing of the vaginal probes will be completed with all Radiology Staff by September 30, 2013. The new cleaning procedure will begin on September 30, 2013 following the completion of staff education. (See Attachment 6-7: Radiology Department Meeting Attendance Record and Radiology Department Meeting minutes). 2. The Metricide log has been revised to add columns to indicate each of the three rinses. Compliance will be monitored by reviewing the log each month to ensure the steps are being followed. This will be reported quarterly to Safety Committee. (See Attachments 8-9: Metricide Log and Radiology Quality Control Report). Changes were recommended to Safety Committee on September 18, 2013 to add Metricide OPA rinsing to the hazardous surveillance survey conducted twice a year by a member of the Safety Committee. This recommendation was approved by those committee members in attendance. (See Attachments 10-12: Proposed Recommendation to Safety Committee, Safety Committee minutes, and Updated Hazard Surveillance Survey). 3. Radiology Staff will be</p>	

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S000598	<p>of the vaginal probes was not being done according to MetraCide manufacturer requirements.</p> <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 Ultrasound Gel containers were properly disinfected before they were refilled with Liquid Sonic Ultrasound Gel located in the CVT.</p> <p>Findings included:</p>	S000598	<p>responsible; Christy Neal, Radiology Supervisor will provide oversight. 4. Completion date September 30, 2013.</p> <p>1. Eight ounce, pre-filled ultrasound gel bottles were ordered and will be used for routine, noninvasive exams. These bottles will be disposed of when empty. Single dose gel packets will be used for invasive procedures and for procedures involving non-intact skin, critically ill children, surgical sites and newborns. This change was approved by the System Manager of Infection Control, and will be implemented on September 30, 2013 following the completion of</p>	09/30/2013

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	<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 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 1:05 PM on 9/4/2013, the CVT Department Ultrasound room was inspected. Located in the room was a table with several 16-ounce ultrasound gel containers. On the table were 7 containers that were partially or just recently filled with the blue ultrasound jell. The room does not have any sterile processing for the gel white plastic containers before they are refilled.</p> <p>3. At 1:10 PM on 9/4/2013, staff</p>		<p>staff education. (See Attachments 1-4: Non-Stock Purchase Requisition, Confirmation of Change to Ordering Template, Pictures of Pre-filled ultrasound gel bottle). Staff education regarding the change to non-refillable Ultrasound Gel bottles will be completed on September 30, 2013. (See Attachments 5-7: Cardiovascular Services Education and Attendance Record, Radiology Department Meeting Attendance Record, Radiology Department Meeting minutes). A revision to the policy for Transthoracic Echocardiogram was completed, in September 2013, to reflect the new practice surrounding ultrasound gel use. This policy will go to the next Infection Control Committee on November 14, 2013 as informational. (See Attachment- CV Services Policy-CVT-20) 2. Only eight ounce pre-filled Ultrasound Gel bottles and single dose gel packets will be ordered and stocked. Changes were recommended to Safety Committee on September 18, 2013 to add a safety check for Ultrasound Gel bottles to the hazardous surveillance survey conducted twice a year by a member of the Safety Committee. This recommendation was approved by those committee members in attendance. (See Attachments 8-10: Proposed</p>		

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	member #11 indicated he/she refills the ultrasound gel plastic bottles without sterilizing and/or disinfecting the containers before they are refilled.		Recommendation to Safety Committee, Safety Committee minutes, and Updated Hazard Surveillance Survey).3. Cardiovascular Department Staff and Radiology Department Staff are responsible with Sunni Shultz, Cardiovascular System Manager and Christy Neal, Radiology Supervisor providing oversight. 4. Completion date September 30, 2013		

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S000912	<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. (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. (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 medical record review, policy and procedure review, and interview, the nurse executive failed to ensure pain assessments were done according to policy for 6 of 10 patients hospitalized</p>	S000912	A- PAIN ASSESSMENTS1a. The Pain Management Performance Improvement Team met September 18, 2013 to review ISDH deficiencies, review pain management policy, and	12/01/2013			

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	<p>for longer than 24 hours (#N1, N4, N9, N11, N12, and N20), failed to ensure assessments were done according to policy for 3 of 3 pediatric patients (#N16, N17, and N18), and failed to ensure physician's orders were carried out for 2 of 10 patients hospitalized for more than 24 hours (#N8 and N13).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient #N1, admitted 03/07/13, indicated pain medication was given orally at 0126 on 03/10/13 and the patient was reassessed at 0321; given at 0858 on 03/10/13 and reassessed at 1140; given at 1139 on 03/10/13 and reassessed at 1444; and given at 1356 on 03/10/13 and reassessed at 1801. 2. The medical record for patient #N4, admitted 06/20/13, indicated pain medication was given orally at 0813 on 06/21/13 and the patient was reassessed at 1406. 3. The medical record for patient #N9, admitted 06/04/13, indicated pain medication was given orally at 1220 on 06/05/13 and the patient was reassessed at 1618. 4. The medical record for patient #N11, 		<p>determine monitoring plan (see Attachments 1-3: Pain Team attendance record and minutes and updated policy)Mandatory pain management policy re-education for all nursing staff to be completed during annual competency assessment program, September 23 and September 30, 2013 (see Attachments 4-6: PowerPoint presentation handout, Competency attendance record, and RN Competencies). As of September 30, 2013, Nursing orientation program to include a review of the pain management policy. 2a. Starting in October after education, monthly medical record review to be completed to monitor compliance with reassessment policies (see Attachment 7: Pain Management PI monitoring tool). Results of monitoring activities will be reviewed by Pain Team and Nursing Leadership Team.3a. Pain Management Team, Nursing Leadership Team and Marina Wolfe, Director of Nursing.4a. Completion date October 2, 2013.B- PEDIATRIC ASSESSMENTS1b. Head circumference measurement moved September 25, 2013 from birth history section of electronic medical record to admission physical assessment (height and weight) section (see Attachment 8: screenshot of electronic medical record assessment).Pediatric Admission</p>				

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	<p>admitted 01/26/13, indicated pain medication was given intravenously at 1238 on 01/29/13 and the patient was reassessed at 1528; given at 1934 and reassessed at 2100.</p> <p>5. The medical record for patient #N12, admitted 02/13/13, indicated pain medication was given intravenously at 0540 on 02/13/13 and the patient was reassessed at 0651; given at 1102 and reassessed at 1311; and given at 1734 and reassessed at 1838.</p> <p>6. The medical record for patient #N20, admitted 08/31/13, indicated pain medication was given orally at 1825 on 09/04/13 and the patient was not reassessed until medication was again given at 2134; given at 0440 on 09/05/13 and reassessed at 0722.</p> <p>7. The medical record for pediatric patient #N16, a six week old admitted 03/30/13, indicated the following: A. No documentation of a head circumference measurement on the admission assessment. B. Documentation of "No" for the question "Are you in Pain?" on the admission assessment, but no pain scale completed. C. A "FLACC" pain scale completed at 0400 on 03/30/13 instead of the "Riley</p>		<p>Assessment policy reviewed and approved September 13, 2013 at Nursing Leadership Team (see Attachment 9 - 10: updated Pediatric Assessment policy and Nursing Leadership minutes). Education regarding pediatric assessment of head circumference and pediatric pain scales to be completed during mandatory annual competency assessment program September 23, 2013 and September 30, 2013 (see Attachments 4-5: PowerPoint presentation handout, Competency attendance record). 2b. Starting in October after education, monitoring of compliance with head circumference and pain assessments to be performed monthly and reported quarterly to Nursing Leadership (see Attachment 11: Pediatric Assessment PI monitoring tool). The Clinical Informatics Director has a team actively working on the issue of content not specific or relevant to the patient appearing in the electronic medical record. When a nurse does NOT select dentures or eye glasses (as in the medical records of the pediatric patients), an entry "Value Not Available-Dentures/Eyeglasses" is incorrectly entered into the electronic medical record. The teams anticipated completion date for this issue is December 1, 2013. 3b. Nursing Leadership Team, Christy Minton, Director of</p>		

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	<p>Infant Pain Scale".</p> <p>D. "Visual correction, glasses and/or contacts in use" and "Dentures in place" documented on the "Eyes, Ears, Nose, and Throat" assessment at 0250 on 03/30/13.</p> <p>8. The medical record for pediatric patient #N17, an 88-day old admitted 02/04/13, indicated the following: A Documentation of a head circumference of 15 under Birth Information, but not on the admission assessment. B. Documentation of "No" for the question "Are you in Pain?" on the assessments from 0800 and 1200 on 02/05/13, but no pain scale completed. C. "Visual correction, glasses and/or contacts in use" and "Dentures in place" documented on the "Eyes, Ears, Nose, and Throat" assessment at 0251 on 02/05/13.</p> <p>9. The medical record for pediatric patient #N18, an 11-month old admitted 05/03/13, indicated the following: A Documentation of a head circumference of 19 under Birth Information, but not on the admission assessment. B. Conflicting information listed on the "FLACC" pain assessment from 1020 on 05/03/13 with "No expression, relaxed</p>		<p>Clinical Informatics, and Marina Wolfe, Director of Nursing. 4b. Completion date December 1, 2013.C - PHYSICIAN ORDERS 1c. Education regarding the follow-through by nursing for physician orders to be completed during the mandatory annual competency assessment program September 23, 2013 and September 30, 2013 (see Attachment 4-5: PowerPoint presentation handout, Competency attendance record).2c. Starting in October after education, monthly monitoring of nursing compliance with orders will be done and reported quarterly at Nursing Leadership (see Attachment 12, Nursing Compliance with Physician Orders PI monitoring data collection tool). Fallouts identified during monitoring will be immediately reported to the Director of Nursing for follow-up with nursing staff. 3c. Nursing Leadership Team and Marina Wolfe, Director of Nursing. 4c. Completion date October 2, 2013.</p>		

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	<p>legs, and quiet, moves easily" documented, but also "crying, screams, sobs" documented.</p> <p>10. The medical record for patient #N8, admitted 06/15/13, indicated a physician order from 1920 on 06/15/13 for Apresoline 10 mg. [milligram] IV [intravenously] every 4 hours as needed for systolic blood pressure greater than 160. The record indicated a blood pressure of 181/98 at 1754 on 06/16/13 and 173/87 at 1826 on 06/17/13, but lacked documentation that the Apresoline was given as ordered.</p> <p>11. The medical record for patient #N13, admitted 02/22/13, indicated physician orders from 2100 on 02/24/13 for 2 bags of fresh frozen plasma to be given followed by 2 units of packed red blood cells, then Lasix 40 mg. after the fresh frozen plasma and after the packed red blood cells. The record only indicated one dose of Lasix was given after the packed red blood cells with no other documentation or explanation.</p> <p>12. The facility policy "Standards of Pain Management", last reviewed 06/12, indicated, "1. All patients will be assessed for pain on admission using the UHC Pain Scale. ...4. Pain will be assesses on a regular basis. For</p>						

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(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>hospitalized patients, reassessment of pain is to be documented: ...d. Within 90 minutes of oral or IM [intramuscular] analgesic administration and 15 to 30 minutes with IV analgesia. ...7. a. The FLACC scale will be used for interpretation of behavioral and nonverbal responses of patients to pain. b. Infants up to three months of age will be assessed for pain using the Modified Riley Infant Pain Scale."</p> <p>13. The facility policy "Pediatric Assessment", last revised 10/12, indicated, "8. Vital signs, weights, and length/heights: ...e. Head circumference will be done on any child who has a suspected growth abnormality, who is less than one year of age, or as ordered by the physician."</p> <p>14. At 3:00 PM on 09/05/13, staff members #P2 and P10 confirmed the medical record findings of pain assessments not done according to policy for both adult and pediatric patients, of head circumference not done according to policy for infants, and of lacking documentation that physician orders were followed.</p>				

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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 observation, manufacturer's directions, and interview, the facility failed to ensure the safety of the staff when handling chemicals in 3 areas (Emergency Department, Housekeeping storage area, and Out-patient Surgery).</p> <p>Findings included:</p> <p>1. During the tour of the Emergency Department at 9:10 AM on 09/05/13, accompanied by staff members #P2 and P23, the housekeeping closet was observed to contain the concentrated chemical Sani-Master for mixing for use by the housekeeping staff. The nearest eyewash station was down the hall through two doorways, one of which had a coded entry, and greater than 50 feet away.</p> <p>2. During the tour of the housekeeping</p>	S001118	<p>1. A proposal was made by the Housekeeping Supervisor to the Infection Control Committee on September 12, 2013 and to Safety Committee on September 18, 2013 to replace the concentrated disinfectant Sani-Master with Virex, a pre-mixed product. This recommendation was approved by the members in attendance at each respective committee. Virex will be used with the pre-mixing dispenser system in the Housekeeping closets. Concentrated cleaning will no longer be needed as the pre-mix dispenser will be used to fill spray bottles and bucket fill for each location. Eye wash stations will not be required with use of pre-mixing dispensers. This transition was completed on September 18, 2013. (See Attachments 1-4: Infection Control Agenda, Infection Control minutes, Safety Committee</p>	09/25/2013	

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	<p>storage area at 10:10 AM on 09/05/13, accompanied by staff members #P2, P9, P23, and P24, various chemicals for mixing, including the Sani-Master, were observed on shelves. The nearest eyewash station was in the lab which was through three doors and greater than 50 feet away.</p> <p>3. During the tour of the out-patient surgery area at 11:05 AM on 09/05/13, accompanied by staff members #P2 and P10, several chemicals, including the Sani-Master, were observed in the housekeeping closet. No eyewash station was immediately accessible.</p> <p>4. Manufacturer's directions on the Sani-Master were to mix one ounce of chemical per gallon of water for proper disinfection. The directions also indicated a 15 to 20 minute flush if the chemical came in contact with the eyes.</p> <p>5. At 9:40 AM on 09/05/13, housekeeping staff member #P24 indicated the housekeeping staff mixed their chemicals for disinfection, sometimes in the specific working area and sometimes in the main housekeeping storage area.</p> <p>6. At 10:15 AM on 09/05/13, staff members #P2 and P9 confirmed that</p>		<p>proposal, and Safety Committee minutes). Education regarding the disinfectant changes was completed on September 17, 2013 with Housekeeping staff. (See Attachment 5-6, Housekeeping Department Meeting Attendance Record and minutes). 2. Only dispensed cleaning solution and ready to use products will be provided for use. Eye wash station will not be required with use of pre-mixing dispensers. 3. Jeff Russell, Housekeeping Supervisor; Mike Mullins, Plant Manager, and Housekeeping Staff. 4. Completion date September 25, 2013</p>				

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	although the areas had quart bottles of flush solution, there was no immediate access to an eyewash station in the areas where chemicals were mixed.			