

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150109	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/11/2013
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 1/7/2013 through 1/11/2013</p> <p>Facility Number: 005096</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 01/17/13</p>	S0000		
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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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and staff interview, the facility failed to ensure 18 hospital services were submitted to the Governing Board for review as defined in the Quality Assurance & Performance Improvement (QAPI) Program and Medical Staff Bylaws.</p> <p>Findings included:</p> <p>1. Franciscan St. Elizabeth Health Administration Quality Assurance & Performance Improvement Program, last revised 12/7/2011, states, "The multidisciplinary Performance Committee will</p>	S0270	<p>Reporting pathways for all departments will be reviewed by 1/31/2013. Deficient hospital service reports will be submitted to the PI Committee via appropriate reporting pathways by 2/7/2013. Following this resolution, PI activities from various areas will be routed via the appropriate pathways at least quarterly. Minutes will reflect the reviews from the various committees involved to the governing board. Person Responsible: Regional Director for QAPI. Monitoring will be completed at least annually to ensure each hospital department has PI activities reported.</p>	02/07/2013

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	<p>provide support and direction for QAPI activities to the Board."</p> <p>2. The Medical Staff Bylaws, last reviewed 4/23/12, notes the Performance Improvement Committee shall be responsible for the overall hospital's Quality Assurance Improvement program. The committee will evaluate all hospital functions and report findings to the Governing Board.</p> <p>3. The Board of Director meeting minutes for 1/1/2012 through 1/1/2013 were reviewed with staff member #1. The Board meeting minutes did not evidence that the following hospital services were brought to the board for quality assurance review and evaluation: Bioengineering; Radiology Services (CT Scanner, MRI, Nuclear Medicine, Diagnostic, Therapeutic, Teleradiology, and Ultrasound); Extracorporeal Shock Wave Lithotripsy; Housekeeping; Laundry; Maintenance; Occupational Therapy; Physical</p>			
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	<p>Therapy; Positron Emission Tomography; Psychiatric - Adult Inpatient; Rehab - Inpatient, and Speech Pathology.</p> <p>3. At 1:15 PM on 1/9/2013, staff member #1 indicated the 18 services were not provided to the Governing Board of Directors for their review.</p>			

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure Extracorporeal Shock Wave Lithotripsy and Housekeeping services were part of its comprehensive quality assessment and improvement (QA&I) program. Findings included:</p> <p>1. Franciscan St. Elizabeth Hospital Quality Improvement Plan, last reviewed 12/7/11, indicates all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p>	S0406	<p>Reporting pathways for all departments will be reviewed by 1/31/2013. Deficient hospital service reports will be submitted to the PI Committee via appropriate reporting pathways by 2/7/2013. Following this resolution, PI activities from various areas will be routed via the appropriate pathways at least quarterly. Minutes will reflect the reviews from the various committees involved to the governing board. Person Responsible: Regional Director for QAPI. Monitoring will be completed at least annually to ensure each hospital department has PI activities reported.</p>	02/07/2013

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	<p>2. Review of department committee meetings and Performance Improvement Committee indicated Extracorporeal Shock Wave Lithotripsy and Housekeeping services were not included in the hospital's comprehensive quality assessment and improvement (QA&I) program.</p> <p>3. At 1:35 PM on 1/9/2013, staff member #1 indicated Extracorporeal Shock Wave Lithotripsy and Housekeeping services are not being monitored through the quality improvement program.</p>				

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S0554	<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 document review, observation, and staff interview, the facility failed to ensure clean supplies are stored in the Morgue in a safe manner and failed to ensure the Plasma Thawing System drain tube was not draining biohazard waste into a hand washing sink located in the Blood Bank.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Storage, Collection and Transportation of Linen policy, last reviewed 5/17/2012, states, "Clean linens will be stored in a clean, dry area that is easily accessible to patient care staff." At 11:00 AM on 1/8/2013, the Pathology Room was inspected. The room was the Morgue of the hospital. The room contained a 	S0554	<p>Items have been moved to a clean, dry area. Education to staff will be completed by 1/31/2013. Chemicals stored by clean items were removed from the area on 1/8/2013 upon identification by the surveyor. Education to staff will be completed by 1/31/2013. A permanent drain for the plasma thawing system will be installed. Until this is completed staff will be instructed not to use the sink for handwashing. Pictures supporting signage to remind staff are included. This will be completed by 1/31/2013. The Director of Laboratory Services will be responsible for ensuring compliance is met and maintained. Monitoring will occur on a monthly basis until compliant for 2 consecutive months. Then quarterly reviews will be initiated.</p>	01/31/2013

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	<p>storage rack of assorted items that was located between the autopsy table and wall mounted storage shelves. The lower rack contained a gallon of bleach, Bactistat disinfectant, etc stored on other cleaned items. The wall mounted shelves were observed with clean uniforms folded on the shelves with over 50 containers of tissue specimens from patients.</p> <p>3. At 11:05 AM on 1/8/2013, staff member #32 indicated his/her units have limited space to store supplies.</p> <p>4. At 11:15 AM on 1/8/2013, staff member #7 indicated the storage of the clean linens and the storage of the chemicals needs to be removed because it was an infection concern.</p> <p>5. At 11:22 AM on 1/8/2013, the Blood Bank room located in the hospital's Laboratory was toured. A hand sink for the room was observed with a soap and paper</p>						

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	<p>towel dispensers mounted on the wall. To the left of the counter hand washing sink was a Helmer Plasma Thawing System. A drain tube exiting the Plasma Thawing System was observed draining into the handwashing sink.</p> <p>6. The Helmer Plasma Thawing System refers to the liquid waste that exit the machine through the drain tube as biological liquid waste. Therefore, the handwashing sink for staff in the Blood Bank Room was also used for draining contaminated waste.</p> <p>7. At 11:28 AM on 1/8/2013, staff member #32 indicated the single bay sink located to the right of the Plasma Thawing System was used for washing hands.</p>				

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations in the Radiology Department.</p> <p>Findings included:</p> <p>1. Cidex OPA manufacture sheet requires: 1) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time</p>	S0596	<p>Test strips which were not dated have been removed. New test strips with appropriate dates have been activated. (Supporting documentation attached for verification). Staff has been re-educated on the process as of 1/31/2013. Manufacturer guidelines are included for review identifying the 2 gallons per rinse. This has been included in the process of Cidex use. A new monitoring process has been developed. This will supplement the monthly monitoring established by infection control. The new process was implemented by 1/31/2013. The Director of Imaging Services will ensure compliance. Monitoring will be at least monthly per the Infection Control policy.</p>	01/31/2013

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	<p>should be done for a minimum of 1 minute. Always use fresh water each time this step is done; and 2) the lids for the test strips and solution need to be tight fitting and to be dated when they were first opened.</p> <p>2. Use of Cidex-OPA for Disinfectant policy #6041-11-006, last revised 2/17/2011, states, "Thoroughly rinse device with water for at least 1 minute for 3 times; using fresh water each time for the rinsing of medical devices. These steps are important for the removal of all oxidizing agent and therefore, must be completed in its entirety without fail. Test strips are not to be used after label expiration date or 90 days from time of opening a new bottle-whichever is first."</p> <p>3. At 11:48 AM on 1/8/2013, the Radiology Department was toured. An open container of test strips were observed in an Ultrasound room for Cidex OPA. The test</p>			

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	<p>strips were not dated when they were first opened. The transducers for the ultrasound equipment was observed in a 32-ounce container of water. The room also had two other 32-ounce containers located near the hand washing sink. Each container had water already in them.</p> <p>4. At 11:52 AM on 1/8/2013, staff member #31 indicated he/she does not rinse the ultrasound probes in fresh 2-gallons of water for each of the 3 rinses. The staff member indicated he/she uses the plastic cylinder 32-ounce containers for rinsing the probes. The staff member indicated the test strips should have been dated when they were first used.</p>						

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S0952	<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 medical record review and interview, the facility failed to ensure physician's orders were followed for blood administration for 2 of 5 patients who received blood transfusions during their hospitalization (#N2 and N5).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient #N2 indicated a physician's order to transfuse 2 units of blood and to give Lasix 40 mg. (milligram) orally prior to each unit. The record indicated the first unit of blood was started at 1455 on 10/02/12, but the Lasix was documented as given at 1804, over 3 hours after the start of the blood. 2. The medical record for patient #N5 indicated a physician's order on 07/24/12 to transfuse 2 units of PRBCs (packed red blood cells). The record indicated the first unit was started at 1925 on 07/24/12, 	S0952	<p>Deviations from medication and/or blood administration are considered medication errors within our facility. Per policy these are reported via our unexpected event pathways, investigated, and corrective action is taken to resolve. Detailed case reviews, discussion with appropriate staff members, and corrective action as outlined by human resources policies/procedures will be completed by 1/31/2013. The Clinical Director for Nursing Practice will be responsible for ensuring compliance. Monitoring will occur on an event-by-event basis as reported via the unexpected event pathway.</p>	01/31/2013			

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	<p>but was stopped at 1941 because of a drop in blood pressure from 118/57 to 61/35. A narrative nursing note from 1950 on 07/24/12 indicated, "at 1925 blood started infusing. at fifteen min. check, blood pressure dropped, 61/35. [physician] aware. Blood stopped and sent to lab per protocol." The medical record also indicated a verbal order from the physician, written by the same nurse, at 1945 on 07/24/12 to transfuse 2 units of washed cells. However, another transfusion record indicated the second unit of PRBCs were started at 2125 on 07/24/12 and stopped at 2140 for another drop in blood pressure from 103/51 to 75/41. Another narrative nursing note by the same nurse at 2200 on 07/24/12 indicated, "pt. had reaction to second unit of blood. Pressure dropped. Infusion stopped. Washed cells ordered per [physician]."</p> <p>The record lacked any documentation of why the second unit of PRBCs were given after the first reaction and there were no other orders from the physician other than the order for the washed cells at 1945 on 07/24/12. The record lacked any further nursing narrative notes to explain the situation.</p> <p>3. During the review of the electronic medical records at 1:15 PM on 01/08/13,</p>			

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	staff members #A12, A37, and A38 confirmed the findings and had no explanation for the discrepancies with the blood and the orders.			

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S1020	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</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>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure outdated drugs were removed from the crash cart on the Behavioral Health Unit.</p> <p>Findings included:</p> <p>1. During the tour of the Behavioral Health Unit at 9:15 AM on 01/08/13, accompanied by staff members #A12 and A27, the crash cart was observed with a label on the outside indicating 3 different medications expired January 1, 2013. The cart was opened and the following injectable medications were observed with an expiration date of 1 Jan., 2013: one of three Atropine 1 milligram (mg.), two of two Dextrose 50 %, and one of one Verapamil 2 milliliter.</p> <p>2. The facility policy "Crash Cart Refill</p>	S1020	<p>The Pharmacy procedure for carash cart refill has been updated to reflect the following language, "A pharmacy technician or pharmacist will check the expiration date and lock of every crash cart during the monthly inspection of the unit where it is kept. If any part of a whole crash cart is going to expire before the next monthly inspection, the pharmacist or technician will inform the unit personnel of the need to get a new cart from CSR and return the expiring one to CSR."The Director of Pharmacy Services will ensure the crash carts are checked for outdated medications and unit personnel are notified.Monitoring will be conducted monthly as per policy.</p>	01/31/2013			

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	<p>Procedure", last reviewed September 27, 2011, indicated, "The pharmacist will place a label on the front of the crash cart that will indicate the first drug to expire and its expiration date. ...A pharmacy technician or pharmacist will check the expiration date and lock of every crash cart during the monthly inspection of the unit where it is kept. If any part of a whole crash cart is going to expire before the next monthly inspection, the pharmacist or technician will inform the unit personnel of the need to get a new cart from CSR and return the expiring one to CSR."</p> <p>3. At 9:15 AM on 01/08/13, staff member #A27 indicated the nursing staff checked the cart daily to ensure it was locked, but it was pharmacy's responsibility to check for outdated medications. No monthly pharmacy check logs were provided prior to exit from the facility.</p>			

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances: Laboratory Blood Bank, Fire Pump Room and obstetrical department.</p> <p>Findings included:</p> <p>1. Safety Management Plan policy #9502-111-04, last revised 7/20/2012, states, "The Mission of the Safety Management Plan is to reduce and control environmental hazards and manage and monitor</p>	S1118	<p>Electrical panels were cleared of all items on top of the boxes 1/8/2013. An inservice for staff was completed on 1/29/2013 discussing the safety concerns and guidelines requiring no storage of items on top of electrical devices was completed on 1/29/2013. All items under the sink in the blood bank were removed 1/8/2013. A reminder to staff not to store items under the sink was added to the area on 1/24/2013. Warming device resolutions include: a. Revision of Warming Compartment policy Completed 1/29/2013; final review/approvals by 2/28/2013 b. Revision of temperature log - completed 1/29/2013 c. Education of staff - completed by 2/1/2013 d. Monitoring for compliance with dating of fluids and recording of temperatures increased - started 2/1/2013 e. Labeling of warming devices with appropriate ranges -</p>	02/06/2013

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	<p>staff activities in order to reduce the risk of injuries. The St. Elizabeth Health Lafayette Safety Program shall adhere to all federal, state and Occupational Safety and Health Administration (OSHA) standards."</p> <p>2. At 10:30 AM on 1/8/2013, the Fire Pump Room was toured. The large red electrical wall mounted panel boxes have a sign posted on them with large lettering on the signs. The signs stated, "DANGER High Voltage". Stored on top of the electrical panels were Towels, an envelope with papers inside of it, plastic wrap, etc.</p> <p>3. At 10:35 AM on 1/8/2013, staff member #10 indicated nothing should ever be stored on top of electrical panels. The staff member indicated this practice is a dangerous practice.</p> <p>4. At 10:53 on 1/8/2013, the Laboratory Blood Bank room was toured. The hand washing under</p>		<p>completed by 1/30/2013f. Manufacturer guidelines for temperature ranges will be determined by 1/31/2013. The Director of the Physical Plant in conjunction with Directors in affected areas will be responsible for ensuring compliance. Monitoring will be part of safety walk-throughs in the impacted areas and the monthly compliance assurance checklist outlined by Infection Control.</p>		

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	<p>counter sink cabinet was inspected. Labratory flasks, chemicals and other supplies were observed stored under the hand washing sink drain pipes.</p> <p>5. At 10:55 AM on 1/8/2013, staff member #7 indicated the hospital procedures requires nothing to be stored under sinks because a drain leak on to supplies could cause an infection control issue.</p> <p>6. During the tour of the nursery at 2:00 PM on 01/07/13, accompanied by staff members #A14 and A15, a small Olympic warmer was observed containing infant blankets and six 500 milliliter bottles of sterile water. The bottles of water were unopened and not dated or timed. A "Warming Cabinet Temperature Log" for January 2013 on the outside of the warmer indicated a temperature recording of 120 for today only, the rest of the sheet was blank. The form indicated, "Date and Time each bag. Max temp 104." Staff member #A14 indicated the fluid</p>			

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	<p>was used for cleaning and procedures such as circumcision of infants.</p> <p>7. At 2:20 PM on 01/07/13, the warmers on the labor and delivery pods were checked with staff members #A15 and A17 and all were found to contain ten 1000 milliliter intravenous bags of lactated ringers solution and twelve bottles of sterile water irrigating solution. None of the bags or bottles were dated or timed. The December 2012 logs indicated the temperatures for the solution warming cabinets ranged from 103 degrees to 119 degrees.</p> <p>8. The facility policy "Warming Cabinets for Blankets and Solutions Monitoring & Cleaning", dated September 20, 2012, indicated, "Purpose: The purpose of the policy is to create a safe environment for our patients by decreasing the likelihood of extreme temperatures when administering fluids or blankets</p>			

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	<p>causing discomfort and/or injury. ...Procedure: ...B. Blanket warming cabinets will be maintained within the recommended temperatures of the manufacturer. C. IV solution warmers will be maintained within the recommended temperatures of the solution manufacturer. D. All types of warming device temperatures will be recorded on the attached temperature log sheet: 1. All patient care areas will obtain and document temperatures daily."</p> <p>9. Manufacturer's literature for the Amsco Steris Warming Cabinet indicated, "2. Temperature of solutions is the responsibility of the surgeon and is a matter of individual professional judgement and practice. In general, temperature of solutions should not exceed 105 degrees F. (Fahrenheit) and should always be checked prior to use. ...7. Blankets can generally be felt by hand by a qualified nurse for patient safe temperature."</p> <p>10. At 4:00 PM on 01/07/13, staff</p>			

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	<p>member #A15 indicated no other temperature logs for the warmer in the nursery could be found.</p> <p>11. At 2:25 PM on 01/08/13, the safety director, staff member #A20, provided literature from the Steris company which indicated, "Abbott Laboratories recommends: IV solutions can be stored up to 2 weeks at 40 degrees C. (Celsius) (104 F) or less. Once removed, discard or use within 24 hours. Irrigating solutions can be stored up to 60 days; semi-rigid containers at 65 degrees C. (150 F) or less. Once removed, use within 24 hours or discard."</p> <p>12. At 2:55 PM on 01/08/13, the pharmacy operations manager, staff member #A39, indicated the facility's fluids were manufactured by Hospira/Abbott and indicated the company was going through some changes and updating policies and would not send them to the facility. However, staff member #A20 provided a letter from the</p>			

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	<p>company to another facility which outlined the temperatures and date requirements of warmed fluids.</p> <p>13. At 11:00 AM on 01/11/13, staff members #A1 and A12 indicated the warmer policy was fairly new and still required some work, but confirmed the fluids were not monitored appropriately.</p>			

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to ensure the dishwasher located in Heartland Perks deli cafe was scheduled and performed a preventive maintenance.</p> <p>Findings included:</p> <p>1. Preventive Maintenance Policy 8341-11-10, last revised 8/23/10, notes that dietary equipment are to be on a Preventive Maintenance schedule and are to be done on a regular routine.</p> <p>2. At 3:05 PM on 1/8/2013, staff member #10 indicated the Heartland Perks front loading</p>	S1164	Preventative maintenance was completed on the dishwasher by 1/9/2013. This piece of equipment will be added to the monthly preventative maintenance system. This will be completed by 1/31/2013. The Director of Physical Plant is responsible for ensuring compliance. Monitoring for preventative maintenance will be conducted monthly.	01/31/2013			

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	industrial dishwasher never was scheduled for a Preventive Maintenance. The staff member indicated the only work order that was found was for a repair on the dishwasher when it was leaking water. The repair work order was submitted by Spencer & Company on 12/23/11.			