STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150086	A. BUILDING 00 B. WING	01/30/2013

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DEARBORN COUNTY HOSPITAL	600 WILSON CREEK RD LAWRENCEBURG, IN 47025

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S0000	This visit was for a standard licensure survey. Facility Number: 005077 Survey Date: 1-28/30-13 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor Cleone Peterson Medical Surveyor QA: claughlin 02/05/13	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (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. Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 directly-provided service and 1 contracted service. Findings: 1. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the directly-provided wound care service and the contracted service of security. 2. In interview, on 1-30-13 at 12:05 pm, employee #A2 confirmed the above indicated and no further documentation was provided prior to exit.	S0270	The deficiency was corrected by the Director of Quality/Risk Management. The department Surgical/Wound was added to the Department Reporting Matrix. The Quality Assurance year 2012 Matrix will be presented to the Board of Directors March 2013. The Surgical/Wound Care Department had completed Quality Monitors "Daily Refrigerator Checks" in 2012. The checks were completed 100% in the 6-month actual performance and 100% in the 12-month actual performance. The Director of Medical/Surgical Units will be responsible for compliance.	02/13/2013

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S0406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include a monitor and standard for 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted service of security. 2. In interview, on 1-30-13 at 12:05 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit.	S0406	The deficiency was corrected by the Director of Quality/Risk Management. The contracted service G4 (Security) was evaluated by the Director of Security and the President/CEO regarding the satisfaction of services year 2012. The contract department G4 (Security) was added to the Department Reporting Matrix. The Quality Assurance Year 2012 Matrix will be presented to the Board of Directors March 2013. The Director of Security will be responsible for compliance. Security now has a monitored standard of "thefts/assaults/police calls reported and community call and responses within 24 hours" on the 2012 Quality Matrix.	02/10/2013

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S0554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the hospital created 2 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors. Findings: 1. On 1-28-13 at 1:45 pm in the presence of employees #A2 and #A3, it was observed in a housekeeping storage area, the following items were stored on open shelves, unwrapped and unprotected: 117 hand towel rolls 75 hand towel packages 23 large toilet paper rolls 2. On 1-28-13 at 2:00 pm in the presence of employees #A2 and #A3, it was observed in the general stores area, the following expired items: 1 box ligaclips - expiration date January, 2001 1 box 9-0 nylon sutures - expiration date April, 2002	S0554	1. The Director of Environmental Services corrected deficiency and will be responsible for compliance. The Maintenance Department installed water protective curtains to enclose the open shelves where dry supplies were stored.2. The Director of Materials Management corrected deficiency and will be responsible for compliance. All expired items were removed from stock and disposed of. Procedure for checking expiration dates on stock was reviewed with staff.	01/30/2013

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	48 2 oz cans Enfamil lipil - expiration date January 1, 2012			

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S0596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on observation and interview, the facility failed to ensure that it had policy & procedures for the Sterad NX sterilizer and Medivator disinfection machines for 1 central sterile processing area. Findings include: 1. During the facility tour of the Central Sterile Processing area on 01-28-13 at 1535 hours, the following was observed: 1 Sterad NX sterilizer & 1 Medivator disinfection machines. 2. On 01-31-13 on 1105 hours, staff #40 confirmed there were no policy/procedures for use of the Sterad NX sterilizer & Medivator disinfection machines.	S0596	The deficiency was corrected by the Director of Surgical Services. The responsible person to monitor is the Director of Surgical Services. Policies for use of Sterrad NX Sterilizer and the use of Medivator disinfector were developed and reviewed with staff in CSR.	02/14/2013

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S0604	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vii) (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: (vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. Based on policy and procedure review, kitchen staff health personnel record review and staff interview, the hospital failed to ensure the immune status for four (#1, 2, 3, 4) of four kitchen health care workers was monitored for the five food transmissible diseases to minimize the risk of secondary spread of infection. Findings: 1. On 1/28/13, between 10:00 a.m. and 11:00 a.m., review of food service policies indicated lack of a policy addressing obtaining history of the five food transmissible diseases for kitchen health care workers. 2. On 1/28/13, between 2:00 p.m. and	S0604	The deficiency is being corrected by the Director of Nutrition. The Director of Nutrition and the Chef will be responsible for compliance.1. Review policy NS 5-5, "Management and Personnel Employee Health" that addresses history of five food transmissible diseases with staff. Competency covering five transmissible diseases was developed and all staff will be required to complete. New employees will be required to review and sign off on policy NS 5-5 of understanding. Any employee with suspected symptoms will be sent to employee health.	02/25/2013

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	3:00 p.m., review of healthcare personnel files for four (#1, 2, 3, 4) kitchen health care workers indicated a history of the five food transmissible diseases had not been obtained. 3. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), if the food employee or applicant: (1) is diagnosed with an illness due to: (A) Salmonella spp.; (B) Shigella spp.; (C) Shiga toxin-producing Escherichia Coli; (D) Hepatitis A virus; or (E) Norovirus" 4. Staff persons #6 & 7 acknowledged on 1/28/13 between 3:00 p.m. and 4:00 p.m. that kitchen health care workers had not been monitored for the five food			

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	transmissible diseases and there was no policy in place to address this issue.			

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S0608	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix) (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: (ix) Requirements for personal hygiene and attire appropriate for work settings. Based on document review, observation and interview, the facility failed to ensure that operating room (OR) personnel followed policy & procedures for surgical attire in the OR for 1 surgery department. Findings include: 1. Review of policy/procedure III.c., Surgical Attire in the OR Suite, indicated the following: "1. All persons who enter the semi-restricted and restricted areas of the surgical suite should wear OR attire that is tightly woven, stain resistant, durable and laundered in the facility. 2. Surgical attire consists of: b. Hair covering (complete)"	S0608	The Director of Surgical Services corrected the deficiency and will be responsible for compliance. OR policy "Surgical Attire in the OR Suite" was updated to reflect that personal surgical caps must be laundered at Dearborn County Hospital or covered with a disposable bouffant cap. Information sent via hospital email to all personnel that disposable skull caps will no longer be available and hair should be covered completely.	02/13/2013

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	This policy/procedure was last reviewed/revised on 05/12. 2. During the facility tour of the Surgery Department on 01-28-13 at 1440 hours, the following was observed in the OR: 1 staff wearing a skull cap with hair exposed. 2 staff wearing personal surgical caps. 3. On 01-28-13 at 1440 hours, staff #43 confirmed the personnel wearing the skull cap had hair exposed and the facility does not launder facility personnel's personal surgical caps and the personnel wearing personal surgical caps should have placed a disposable cap over the personal cap.			

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S0732	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. Based on document review, observation and interview, the facility failed to ensure that the medical record (MR) contained sufficient information to justify the treatment and document accurately the course of treatment and results for 4 of 22 MRs reviewed (Patient #2, 11, 15 and 22). Findings include: 1. Review of patient #11's MR indicated the physician ordered the Clinical Pathway for hip fracture fixation/hemiarthroplasty on 11-19-12. The Clinical Pathway for hip fracture fixation/hemiarthroplasty indicated that neuro/circulation checks were to be done every 4 hours for 2 days. The patient's MR lacked documentation that the neuro/circulation checks were completed. 2. On 01-31-13 at 1155 hours confirmed that patient #11's MR lacked	S0732	The Vice President of Patient Care Services corrected the deficiency and the Directors of all patient care units will be responsible for compliance.1 & 2. The order for neuro/circulation checks was on the Clinical Pathway for hip fracture fixation/hemiarthroplasty, but was not on the order set for this procedure. This order was added to the hip fracture fixation order set and education provided to staff.3. Protocol for post-op anesthesia physician orders was reviewed with PACU nurses and anesthesia providers. The charge nurse in PACU will be responsible for compliance.4-7. The ICU Unit Coordinator/Charge Nurse will have the responsibility of ensuring all orders are present, signed, and dated for every patient in restraints daily. Intra-hospital email was sent to all ICU staff to review restraint policy. An Improved Organizational Performance Plan has been implemented in the ICU for 2013 to ensure compliance to	02/18/2013

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	documentation of the neuro/circulation checks were completed. 3. Review of patient #15's MR indicated the physician wrote the following orders on 10-16-12 at 1515 hours and 1530 hours: Dilaudid 0.4 - 0.8 mg IV push q 10 minutes as needed. PCA Dilaudid 0.2 mg/ml, loading dose 1 mg. Review of patient #15's MR indicated the following was administered on 10-16-12: Dilaudid 1 mg IV at 1530 hours. Dilaudid 1mg at 1540 hours. Dilaudid 1 mg at 1545 hours. Patient #15's MR lacked documentation that the loading dose of Dilaudid 1 mg was given when the PCA was started at 1610 hours. 4. During the facility tour of the Intensive Care Unit (ICU) on 01-29-13 at 1010 hours, patient #2 was observed to have bilateral soft wrist restraints on. 5. Review of patient #2's MR indicated the patient was restrained on 01-22-13 at 2010 hours. The MR indicated the patient had been restrained since 01-22-13. Patient #2's MR lacked documentation of Physician Restraint Orders to be restrained on 01-22-13 and lacked documentation of any renewal orders for		Restraint Policy.Medical Record random audits of 10 charts a month for 6 months will be completed. Accepted threshold will be 100% compliance.	

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	the patient to be restrained. 6. On 01-29-13 at 1020 hours, staff #41 confirmed the orders for restraint were not completed in patient #2's MR. 7. Review of patient #22's MR indicated the patient was restrained on 10-25-12 at 0715 hours and was restrained to 10-31-12 at 1000 hours. Patient #22's MR lacked documentation of Physician Restraint Orders to be restrained on 10-25-12 was signed by the physician and lacked documentation of any renewal orders for the patient to be restrained.			

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S0754	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on document review and interview the facility failed to ensure that informed consent forms for procedures were complete for 5 of 6 surgical medical records (MR) reviewed (Patient #11, 12, 13, 14 & 15). Findings include: 1. Review of policy/procedure ADM112, Consent - Obtaining and Verifying Informed Consent, indicated the following; "The hospital has to verify that indeed the physician has obtained the patient's informed consent. Evidence of informed consent is one of the required documents in a complete medical record." This policy/procedure was last reviewed/revised on 01/12.	S0754	The deficiency was corrected by the Director of Surgical Services and the Director of Quality/Risk Management. The statement, "I understand the type of anesthesia that will be used on me will be _____", was removed from the consent form as the specific type of anesthesia is not always known when the consent is signed. The consent still states that risks and complications of anesthesia have been explained. Anesthesia will continue to document plan for type of anesthesia in their Plan of Care pre-op documentation.	02/14/2013

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	2. Review of patient #11, 12, 13, 14 & 15's MR indicated that each had surgery and the consent form was blank where it stated, "I understand the type of anesthesia that will be used on me will be_____." 3. On 01-31-13 at 1225 hours, staff #42 confirmed that the blank was supposed to be filled in with type of anesthesia used.			

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	150086	A. BUILDING 00 B. WING	01/30/2013

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S0952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (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 policy/procedure review, transfusion record review, and staff interview, the facility failed to administer blood in accordance with approved medical staff policies and procedures for one (T#3) of seven units reviewed. Findings included: 1. Review of a policy titled "BLOOD ADMINISTRATION, NURSING POLICY & PROCEDURE FF-2" on 1/30/13 between 9:30 a.m. and 10:00 a.m. indicated the following: "An Acknowledgement of Informed Consent, Transfusion of Blood Products, must be signed by the patient or guardian, as well as the physician or registered Nurse." 2. Transfusion record review on 1/30/13 between 10:00 a.m. and 11:30 a.m. indicated Transfusion #3 (T#3) did not have documentation of a signed "Acknowledgement of Informed Consent" available for review in the paper or the	S0952	The Vice President of Patient Care Services is correcting this deficiency. All Directors of patient care areas will be responsible for compliance. An intra-hospital email was sent to all nursing staff to review policy FF-2, "Blood Administration" and to ensure that a consent for Transfusion of Blood Products is signed prior to any blood transfusions. Blood administration has been placed as a competency for all nursing staff RN/LPN in 2013. Medical record audits of 10 charts a month for 6 months will be completed. Accepted threshold will be 100% compliance.	02/18/2013

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	electronic file. 3. On 1/30/13, staff persons #3, 4, and 8 acknowledged the lack of a signed consent for T#3.			

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S1022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation and interview, the facility failed to have a policy for appropriate storage condition regarding food product and medications being stored together. Findings: 1. On 1-29-13 at 2:10 pm in the presence of employees #A2 and #A3, it was observed in the Pharmacy, there was a large refrigerator containing both medications and food products. 2. In interview, on the above date and time, hospital staff indicated the food belonged to employees. 3. In interview, on the above date and time, hospital staff was requested to provide a policy indicating it was appropriate to store food products and medications together. No such policy was	S1022	The Director of Pharmacy has corrected this deficiency and will be responsible for compliance. Food has been removed from the medication refrigerators. Policy IC 419, "Refrigerator/Freezer Storage," was updated with the statement, "Medications and food products should not be stored in the same refrigerator." Safety rounds are performed every six months for compliance.	02/18/2013

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	provided prior to exit.			

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S1028	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, document review and interview, the hospital failed to ensure secure access to 1 drug storage area within the hospital. Findings: 1. On 1-28-13 at 1:05 pm in the presence of employees #A2 and #A3, it was observed in a cabinet in the radiology hallway adjacent to an MRI unit, a key was in the cabinet door, the door was open, and the following medications were in the cabinet: Isovue 370 - 100 ml - 14 bottles Isovue 370 - 500 ml - 1 bottle Isovue 370 - 150 ml - 14 bottles Isovue 300 - 100 ml -18 bottles Barium Sulfate Suspension - 450 ml - 62	S1028	The Director of Imaging corrected this deficiency and will be responsible for compliance. Staff will be educated on existing policy RAD-CON #2 that addresses securement of medications. The key to the cabinet is secured in locked drawer in CT control room.	01/30/2013

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	bottles 2. On the above date and time, it was also observed there were no departmental personnel in or observing the area. 3. Review of PHARMACY SERVICES DEPT. POLICY & PROCEDURE PM - 96, entitled KEY SECURITY AND CONTROL, reviewed August, 2012, indicated keys to medication storage areas are stored in a [sic] appropriate, pre-determined locations when not in use.			

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S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and document review, the hospital created conditions which resulted in a hazard to patients, public or employees in 3 instances. Findings: 1. On 01-28-13 at 12:30 pm in the presence of employees #A2 and #A3, it was observed in the Sleep Lab lobby area, there was 1 fire extinguisher on the floor unsecured by chain or holder. 2. On 01-29-13 at 2:10 pm in the presence of employees #A2 and #A3, it was observed in the Pharmacy expansion area being renovated, there was 1 fire extinguisher on the floor unsecured by chain or holder. 3. Review of Policy & Procedure SAF 321.1, entitled PORTABLE OXYGEN	S1118	The Director of Quality/Risk Management corrected the deficiency. The Environmental Rounds Committee will be responsible for compliance.1. Fire extinguisher was secured in the Sleep Lab lobby by Maintenance. 2-4. Fire extinguisher was secured in a holder by Maintenance personnel.5-6. Alcohol-based hand sanitizer dispenser was removed by Maintenance personnel.	01/30/2013

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	CYLINDERS WITH SEPARATE GAUGES, section PRECAUTIONS, reviewed 6/12, indicated cylinders must be securely attached to a wall, supported by a cylinder stand or a hand cart. 4. If any of the above extinguishers were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property. 5. On 01-28-13 at 12:25 pm in the presence of employees #A2 and #A3, it was observed in the Sleep Lab lobby, there was an alcohol-based hand sanitizer (ABHS). The area was carpeted and not sprinklered 6. The alcohol-based hand sanitizer posed a fire hazard since the area was carpeted and unsprinklered.			

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S1150	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9) (c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following: (9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department. Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance. Findings: 1. On 1-28-13 at 12:45 pm in the presence of employee #A2 and #A3, it was observed in the renal dialysis storage room, there was a flexible hose connected to a water spigot without a backflow prevention device.	S1150	The Director of Quality/Risk Management corrected the deficiency. The Environmental Rounds Committee will be responsible for compliance. A backflow prevention device was installed by Maintenance personnel.	01/30/2013

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S1168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and interview, the hospital failed to properly keep a discharge log for 3 of 3 defibrillators. Findings: 1. Review of a hospital policy entitled RESPONSIBILITIES OF CODE TEAM MEMBERS, approved 9-6-12, indicated discharge defibrillator in test **mode daily** for the **Monophasic** and **7AM & 7PM in Pads/cable & Paddles mode** for the **Biphasic** monitor defibrillator. 2. Review of a document entitled ADULT CRASH CART SUPPLIES/DAILY CHECK REQUIRED for the PET/CT Unit/Dept. indicated the Monophasic Defib Tested daily was not done on January 1, 29, 30 and 31, 2013. 3. Review of a document entitled ADULT CRASH CART SUPPLIES/DAILY CHECK REQUIRED	S1168	The deficiency was corrected by the Director of Quality/Risk Management. The Directors in each area where defibrillator checks are performed will be responsible for compliance.2. An AED was placed in the CT area and CT personnel will check daily. Policies were updated to reflect this.3-4. Previous forms that included Monophasic and Biphasic checks on the same form were revised. Areas that only require Monophasic checks now have a form with area for Monophasic check only. Areas that have Monophasic and Biphasic checks now have a form that has signature for each of these checks. Education provided for staff during unit meetings. The Charge Nurse on each shift will either complete check or ensure check is completed.	02/14/2013

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	for the ICU Unit/Dept. indicated the Biphasic Defib Tested q12hrs Pads/cable & Paddles checks were not done as follows: 7AM - January 6, 13, 26, 27, 30 and 31, 2013 7PM - January 14, 25, 27, 29, 30, 31, 2013 7AM - December 1, 2, 7, 15, 21, 22, 23, 28, 29, 2012 7PM - December 3, 4, 5, 6, 9, 11, 14, 19, 20, 24, 27, 29, 30, 2012 4. Review of a document entitled ADULT CRASH CART SUPPLIES/DAILY CHECK REQUIRED for the ED Unit/Dept. indicated the Biphasic Defib Tested q12hrs Pads/cable & Paddles checks were not done as follows: 7AM - January 4, 6, 24, 29, 30, 31, 2013 7PM - January 2, 5, 9, 10, 11, 13, 17, 25, 26, 28, 29, 30, 31, 2013 7AM - December 20, 23, 30, 31, 2012 7PM - December 1, 4, 5, 9, 10, 11, 13, 14, 15, 16, 18, 19, 22, 23, 25, 28, 29,30, 31, 2012			

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