

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150002		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/06/2013	
NAME OF PROVIDER OR SUPPLIER  METHODIST HOSPITALS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402			
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005002</p> <p>Survey Date: 06/3, 4, 5 &amp; 6/2013</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/17/13</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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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the hospital policies and procedures were not reviewed and updated triennially.</p> <p>Findings:</p> <p>1. Document review with Employee #A2 on June 4, 2013 at 4pm indicated the hospital policy "CORP_26 Policy Review" was "approved by the CEO 11/2008" and "review on 11/11" By whom was not given, no names, titles, signatures nor initials.</p> <p>2. In interview with Employee #A2 on June 4, 2013 at 4pm, #A2 confirmed the hospital policy "CORP_26 Policy Review" was "approved by the CEO 11/2008" and "review on 11/11" By whom is not given, no names, titles,</p>	S000322	<p><b>Actions Taken:</b></p> <p>At the time of the on-site survey, our on-line policy program did not have a mechanism to quickly identify policy expiration dates. To see the expiration date, you had to open each PDF policy and scroll to the end where the signatures and dates were located. This was a flaw in the system that allowed some policies to expire past the 3-year review date without notification to the appropriate leader.</p>	07/02/2013			

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	<p>signatures nor initials.</p> <p>3. No further documentation was given prior to exit.</p>		<p>Since the survey, our internal on-line policy program was improved to include a table with expiration dates for every policy.</p> <p>This information is now used to send notices to responsible leaders at 90, 60 and 30 days prior to the expiration of all policies. At the 30-day notification, the responsible Vice President is included in the notification. All Leaders are required to update their policies and send them for proper approval within the required review period, according to policy or regulation.</p> <p>This information is also used to run status reports. We are now able to identify any outdated policy, at any time.</p> <p><b>Responsible Person:</b> Director, Quality Services</p>		

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			<p><b>Completion Date:</b> Policy program updated, process established, complete.</p> <p><b>Prevent Recurrence:</b></p> <p>A status report is reviewed by the Policy and Procedure Committee monthly. If non-compliance patterns/trends are identified, action is taken. This could include disciplinary action, as appropriate according to the hospital's HR policy.</p> <p><b>Responsible Person:</b> Director, Quality Services</p> <p><b>Completion Date:</b> Monitoring process established, complete. Monitoring is ongoing.</p>		

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S000362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and employee interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.</p>	S000362	<b>Actions Taken:</b> ALL inpatient care staff was required to complete on-line education reviewing the Organ Procurement Organization (OPO) notification process. (Attachment: OPO	08/24/2013			

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	<p>Findings:</p> <p>1. Review of the contract between the hospital and the Gift of Hope indicated the hospital shall provide "Timely Notification of all individual who have died or whose death is imminent".</p> <p>2. Review of the documentation presented failed to show all deaths were reported. Donation Activity Report July-October 2011 indicated 25 deaths occurred in September 2011 and only 24 deaths were reported.  Donation Activity Report for 4th Quarter 2012 indicated 37 deaths occurred in January 2012 and only 36 deaths were reported;  Donation Activity Report for 4th Quarter 2012 indicated 38 deaths occurred in February 2012 and only 37 deaths were reported;  Donation Activity Report for 4th Quarter 2012 indicated 38 deaths occurred in March 2012 and only 37 deaths were reported.</p> <p>3. Interview with Employee #A2 on June 3, 2013 at 1:30pm, verified the all deaths had not been reported.</p>		<p>Education) The education was posted on June 24 th with a required completion date within 60 days, by August 24 th .</p> <p><b>Responsible Person to Post and Track Education:</b> Director, Nursing Education  <b>Responsible Person for 100% Staff Completion by August 24 th :</b> Unit Managers  <b>Completion Date:</b> 08/24/13 Education was provided through a "Need to Know," sent out to patient care services. (Attachment: Need to Know #60). The one-page educational communication outlined the process for notifying the OPO when a patient dies. The Unit Manager and/or House Manager must confirm the OPO notification process has occurred for ALL deaths. <b>Responsible Person to Send NTK:</b> Director, Nursing Quality  <b>Completion Date:</b> 06/21/13, complete. Unit Managers and House managers are ultimately responsible for the completion of Form 7531-7. House Managers will provide education to nursing staff on how to complete Form 7531-7 by attending one nursing staff meeting for all patient units by the end of the year. <b>Responsible Person:</b> House Managers  <b>Completion Date:</b> 12/31/13  <b>Prevent Recurrence:</b> Unit Managers and House Managers concurrently monitor the process for compliance. Gift of Hope (OPO) audits every chart to</p>		

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			<p>ensure death notification has occurred. The Director of Nursing Quality reviews the OPO data to verify all deaths are reported. If non-compliance patterns/trends are identified, action is taken. This could include disciplinary action, as appropriate according to the hospital's HR policy.</p> <p><b>Responsible Person:</b> Director, Nursing Quality <b>Completion Date:</b> Monitoring process established, complete. Monitoring is ongoing.</p>		

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the facility failed to implement its policy regarding prevention of noscomial varicella in the healthcare setting in relation to reliable determination of employee immunity status for varicella in 7 of 21 employees whose personnel files were reviewed (P2, P3, P4, P6, P7, P8, P19).</p> <p>Findings included:</p> <p>1. Facility policy "Varicella Vaccine Program", last reviewed/revised 12/2011, stated on page 1, Policy "This procedure establishes a program for varicella vaccination of health care workers who</p>	S000606	<p><b>Actions Taken:</b> Employee Health performed an audit and determined that self-reporting of Varicella was accepted without proof of exposure for the past 12 months. All employee health records for new hires within the past 12 months were reviewed. Staff was contacted and Varicella titers were drawn, if needed.</p> <p><b>Responsible Person:</b> Manager, Employee Health <b>Completion Date:</b> 07/20/13 All new hires are required to have a Varicella titer drawn. <b>Responsible Person:</b> Manager, Employee Health <b>Completion Date:</b> 07/20/13. Process is ongoing.</p> <p><b>Prevent Recurrence:</b> Varicella titer is included in the required new hire testing that must be</p>	07/20/2013			

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	<p>are found to be non-immune or equivocal to varicella. A successful varicella program will help prevent the occurrence of nosocomial varicella in the healthcare setting", and under Guidelines "All prospective employees will be screened for varicella antibody prior to initiating their work assignment. All non-immune varicella employees will be required to have one dose of varicella vaccine prior to initiating employment. The second dose of the vaccine will be scheduled 4-8 weeks after the initial dose".</p> <p>2. During review of personnel files on 6-4-13 and 6-5-13 with S13, 6 of 21 health records lacked documentation of a varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history:</p> <p>a. P2, a CNA, was hired 10-10-2011 and had been providing direct patient care. Employee health screening contained a self-attestation of history of varicella but lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P2 vaccination to varicella as per policy.</p> <p>b. P3, an RN, was hired 7-9-2012 and had been providing direct patient care.</p>		<p>completed before an employee is officially hired. <b>Responsible Person:</b> Manager, Employee Health <b>Completion Date:</b> 07/20/13. Process is ongoing.</p>		

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	<p>Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P3 vaccination to varicella as per policy.</p> <p>c. P4, an RN, was hired 3-12-2012 and had been providing direct patient care. Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P4 vaccination to varicella as per policy.</p> <p>d. P6, an RN, was hired 5-9-2011 and had been providing direct patient care. Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P6 vaccination to varicella as per policy.</p> <p>e. P7, a CST, was hired 8-13-2012 and had been providing direct patient care.</p>				

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	<p>Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P7 vaccination to varicella as per policy.</p> <p>f. P8, a CST, was hired 8-13-2012 and had been providing direct patient care. Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P8 vaccination to varicella as per policy.</p> <p>g. P19, a CST, was hired 8-24-2011 and had been providing direct patient care. Employee's health screening contained a self-attestation of history of varicella but file lacked documentation of varicella antibody, reliable documentation of previous immunization, or reliable documentation of disease history. There was no record that the facility had given P19 vaccination to varicella as per policy.</p> <p>3. During interview with S15 on 6-6-13 at approximately 10:30 AM, S15:</p> <p>a. confirmed the findings in the personnel</p>				

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	<p>files for P2, P3, P4, P6, P7, P8, and P19.</p> <p>b. indicated the Infection Control Program follows CDC and APIC recommendations and that reliable documentary proof of immunity to varicella would be a practitioner's diagnosis of disease, a titer showing positive immunity, or reliable documentation of immunization to varicella.</p> <p>c. indicated the above employees were not offered vaccination to varicella by the facility as per policy and that absent a positive titer for varicella, reliable documentation of disease history for varicella, or reliable documentation of immunization to varicella, an employee's communicable disease status as to varicella could not be reliably determined.</p> <p>d. indicated facility did not have a policy mechanism in place to exclude these employees from the healthcare setting in the event of a community outbreak of varicella to prevent the risk of infection exposure to patients in the facility who are not immune to varicella.</p> <p>e. indicated personnel files for the above employees were not documented in accordance with facility policy.</p>				

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S001110	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-9 (a)(2)</p> <p>(a) The hospital shall be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for services authorized under the hospital license as follows:</p> <p>(2) There shall be a safety officer designated to assume responsibility for the safety program.</p> <p>Based on document review and interview, the hospital failed to designate a safety officer responsible for the safety program.</p> <p>Findings:</p> <p>1. Document review on June 4, 2013 at 12:05pm with Employee #A11, indicated "hospital policy #SAF_22 Safety Officer Responsibility/Authority. Policy review and approval by Vice President Operations 3/2009 and Safety Committee 8/26/2008".</p> <p>2. Safety Committe Meeting Minutes on April 16, 2013 indicated review of hospital policy #SAF_22 with recommendations/actions indicating "The Committee suggests (Employee #A11) address the issue with (Employee) regarding the Policy."</p>	S001110	<p><b>Actions Taken:</b></p> <p>The President/CEO appointed a Safety Officer for Methodist Hospitals. (Attachment: Safety Officer Appointment Letter) The Safety Officer is responsible for overseeing the development, implementation and monitoring of safety management at Methodist Hospitals. (Attachment: Safety Officer Job Description)</p> <p><b>Responsible Person:</b> President/CEO</p> <p><b>Completion Date:</b> 7/1/13, complete.</p>	07/01/2013			

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	3. Upon interview with Employee #A11, #A11 indicated that "the issue" referred to in the meeting minutes April 16, 2013 is the hospital has no designated safety officer.		<p><b>Prevent Recurrence:</b></p> <p>In the event the position of Safety Officer is vacated in the future, the President/CEO will appoint an interim Safety Officer until a permanent Safety Officer can be appointed. There will be no gap in coverage.</p> <p><b>Responsible Person:</b> President/CEO</p> <p><b>Completion Date:</b> Monitoring is ongoing.</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, review of manufacturer's labels, and staff interview, the hospital failed to properly store 17 of 57 ready to hang feeding containers of "Jevity 1.2 CAL High-Protein Nutrition with Fiber" and 8 of 40 ready to hang feeding containers of "Nepro with Carbsteady Therapeutic Nutrition" to ensure the well-being of patients in 1 area (Kitchen) and failed to monitor the temperature and maintain the condition of blanket/solutions warmers to assure safety of its patients and the prevention/reduction of fire risk for 2 of 2 areas toured (Surgical Services and Maternal Child Health).</p> <p>Findings include:</p> <p>1. During tour of the kitchen on 6-4-13 between 10:45 AM and 12:30 PM while accompanied by Staff Members #4 and #16, 17 ready to hang bottles of "Jevity 1.2 CAL High-Protein Nutrition</p>	S001118	<p>STORAGE OF NUTRITIONAL SUPPLEMENTS <b>Actions Taken:</b> Food Service stores bottles in the original boxes until it is used to prevent any exposure to light. After delivery to patient care units, Nursing stores tube feedings in cabinets until use. If the bottles are not needed after delivery to the patient care unit, Nursing returns the un-opened bottles to Food Service for proper storage. When bottles are returned to Food Service, they are returned to boxes for storage to prevent exposure to light. Food Service staff was given an in-service on proper storage of tube feedings immediately following the survey. An additional in-service was provided to food service and food storeroom staff to reinforce the storage requirements for nutritional supplements.</p> <p><b>Responsible Person for Food Service Education:</b> Director, Food and Nutrition <b>Completion</b></p>	07/31/2013			

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	<p>with Fiber" and 8 ready to hang bottles of "Nepro with Carbsteady Therapeutic Nutrition" were observed in the dry storage area placed on boxes, exposed to light.</p> <p>2. Review of manufacturer's labels on 6-4-13 between 10:45 AM and 12:30 PM revealed the following:</p> <p>a. "Jevity 1.2 CAL High-Protein Nutrition with Fiber," copyright "2012" by "Abbott Laboratories" read: "Contains Light-sensitive nutrients."</p> <p>b. "Nepro with Carbsteady Therapeutic Nutrition," copyright "2012" by "Abbott Laboratories" read: "Contains light-sensitive nutrients."</p> <p>3. In interview on 6-4-13 between 10:45 AM and 12:30 PM, Staff Members #4 and #16 acknowledged the manufacturer's labels indicated they enteral feeding containers should not be exposed to light while stored.</p>		<p><b>Date: 7/5/13</b> Nursing staff was educated on the proper storage of bottled tube feedings. (Attachment: Need to Know #61)</p> <p><b>Responsible Person for Nursing Education:</b> Director, Food and Nutrition and Director, Nursing Quality <b>Completion Date:</b> 7/2/13, complete.</p> <p><b>Prevent Recurrence:</b> Food Service and Nursing staff are responsible for monitoring compliance with proper storage on an ongoing basis. Proper storage of tube feedings is checked weekly during scheduled EOC rounds. If non-compliance patterns/trends are identified, action is taken. This could include disciplinary action, as appropriate according to the hospital's HR policy.</p> <p><b>Responsible Person:</b> Director, Food and Nutrition and Nursing Directors <b>Completion Date:</b> Process established, complete. Monitoring is ongoing. <b>BLANKET WARMERS</b><b>Actions Taken:</b> Thermometers were ordered and received for all blanket warmers in the hospital.</p> <p><b>Responsible Person:</b> Director, Plant Operations<b>Completion Date:</b> Thermometers received, complete. Thermometers to be installed in all blanket warmers.</p> <p><b>Responsible Person:</b> Director, Plant Operations<b>Completion Date:</b> 7/8/13 A policy and procedure on monitoring blanket</p>		

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			<p>warmers to be written. The policy will outline the process for monitoring blanket warmers. It will include a tool to document temperatures on a daily basis and document actions taken when temperatures fall out of compliance. The policy will be based on the recommended practices for a safe environment of care referenced in the Perioperative Standards and Recommended Practices (Denver CO: AORN, Inc; 2012; e37-e61); Hazard Report, ECRI Institute Revises its Recommendation for Temperature Limits on Blanket Warmers (Health Devices, 2009; 38(7):230-231; updated November 30, 2012). They recommend:</p> <ul style="list-style-type: none"> <li>·The temperature range of blanket or linen warming cabinets should not exceed 130°F (54.4°).</li> <li>·Post the temperature parameters on the cabinet for ready reference.</li> <li>·The temperature of the warming cabinet should be checked on regular intervals and documented on a log or electronically.</li> </ul> <p><b>Responsible Person for Policy:</b> Director, Surgical Services <b>Completion Date:</b> 7/15/13 Education to be provided to caregivers who work in areas with blanket warmers.</p> <p><b>Responsible Person:</b> Director, Surgical Services (Oversight), Unit Managers <b>Completion Date:</b> 7/31/13 <u>Prevent</u></p>		

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	<p>4. During tour of the facility on 6-3-2013, 6-4-2013, and 6-5-2013, in the presence of S5, the following was observed on patient care units:</p> <p>a. During tour of the surgical services areas of both campuses, all the blanket warmers in the Surgical Services areas were set above 130 degrees. (170 degrees in Northlake surgical service operating room area, 160 degrees in Northlake Cath lab blanket warmer, 180 degrees in Northlake (preoperative/endoscopy area, 140 degrees in Southlake Cath lab). The warmers contained blankets but not solutions. All of the blanket warmers lacked a method of determining the temperature of the blankets in the warmer (central temperature regulation through plant maintenance, or a thermometer in the warmer, or a temperature sensor incorporated into the unit's controls). S9, manager of surgical services indicated</p>		<p><b>Recurrence:</b> The temperature logs will be checked during monthly EOC rounds. If non-compliance patterns/trends are identified, action is taken. This could include disciplinary action, as appropriate according to the hospital's HR policy. <b>Responsible Person:</b> Unit Managers <b>Completion Date:</b> Monitoring to begin in August 2013. Monitoring is ongoing.</p>		

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	<p>that the blanket warmers were not monitored/regulated to keep the temperature for blankets at 130 degrees or less, and the temperature for solutions at 110 degrees or less (if used to warm solutions), no log had been maintained showing the temperature regulated within safe limits and showing evidence of routine cleaning to disinfect and to remove accumulations of lint. S9 indicated the facility followed AORN recommendations for the surgical services department (130 degrees or less for blankets and 110 degrees or less for solutions), the blankets warmers were set above the established standard of care, and the overheated blankets could present a risk to patients. S9 was not aware of a facility policy or procedure for the use and care of blanket/solution warmers.</p> <p>b. During tour of Maternal Child Health units (MCH) at Southlake campus, the blanket warmer contained blankets and solutions and was set between 160 and 170 degrees. The warmer contained both blankets and irrigation solutions (Sterile Water and 0.9% Sodium Chloride). The blanket warmer lacked a method of determining the temperature of the blankets/solutions in the warmer (central temperature regulation through plant maintenance, or a thermometer in the</p>				

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	<p>warmer, or a temperature sensor incorporated into the unit's controls). The upper compartment was observed to have an accumulation of lint and dust. S6, manager of MCH, indicated the unit had not kept a log to monitor the blanket/solution warmer temperature, had not assigned the duty to clean and regulate the temperature to either nursing or housekeeping, and was not aware of a facility policy or procedure for the use and care of blanket warmers. S6 indicated that overheated solutions/blankets could pose a safety risk to patients and that lint accumulation presented a fire hazard.</p> <p>5. During interview with S5 on 6-4-2013 at approximately 2:00 PM, S5 indicated the facility did not have a policy addressing the care and temperature regulation/monitoring of its blanket/fluid warmers. S5 indicated the facility follows AORN recommendations for its surgical services areas and acknowledged that the standard of care for patient safety and facility safety was to regulate and monitor the temperature and condition of its blanket/solution warmers (130 degrees or less for blankets and 110 degrees or less for solutions) to prevent the risk of burn to patients and the risk of fire due to accumulation of lint inside the equipment.</p>				

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S001124	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on document review and interview, the hospital failed to show evidence of a current and approved policy regarding the fire alarm system.</p> <p>Findings:</p> <p>1. On June 4, 2013 at 4pm document review and interview with Employee #A2 indicated the hospital policy PO_56 Policy on Fire Alarm Systems was reviewed and approved by the" Vice President of Operations 8/2009".</p> <p>2. Employee #A2 indicated at this time</p>	S001124	<p><b>Actions Taken:</b></p> <p>The Director of Plant Operations reviewed the Policy on Fire Alarm System (PO_56) and made no changes. The policy was reviewed and approved by the Vice President of Operations and the Safety Committee.</p> <p><b>Responsible Person:</b> Director,</p>	08/30/2013			

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	that this is the most current policy. No further documentation was presented prior to survey exit.		<p>Plant Operations</p> <p><b>Completion Date:</b> 7/5/13</p> <p>The policy is scheduled to be reviewed at the next Culture of Safety Committee meeting and then will be presented at the following Leadership Performance Improvement Council meeting. Once reviewed by these committees, the policy will be posted on the on-line policy system.</p> <p><b>Responsible Person:</b> Director, Plant Operations</p> <p><b>Completion Date:</b> 8/30/13</p> <p><b>Prevent Recurrence:</b></p> <p>The Director of Plant Operations will be sent electronic notification at 90, 60 and 30 days prior to the</p>		

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			<p>expiration of this policy. At the 30-day notification, the Vice President of Operations will be included in the notification. The Director of Plant Operations is required to update the policy and send for proper approval within the required review period, according to policy or regulation.</p> <p><b>Responsible Person:</b> Director, Plant Operations <b>Completion Date:</b> Process established, complete. Monitoring is ongoing.</p>		