

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2011
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NAME OF PROVIDER OR SUPPLIER MARION GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 441 N WABASH AVE MARION, IN46952
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 11/28/2011 through 11/30/2011</p> <p>Facility Number: 005011</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 12/09/11</p>	S0000		
S0332	<p>410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and staff interview, the facility failed to ensure 1 of</p>	S0332	Item # S 332; # 1 & 2 1. Staff member #66 will be reevaluated using the correct job description,	12/23/2011

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

TITLE

(X6) DATE

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

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	<p>2 Paramedics had documented competency in fulfilling assigned responsibilities for Paramedic Job Description (#66).</p> <p>Findings included:</p> <p>1. The facility provided personnel records for two Paramedics. Each Paramedic had a different job description and essential job functions and competency checklists. Paramedic staff member #65 job specifications included Advance Life Support, Current ACLS Training, etc. Paramedic Staff member #66 was provided a Paramedic Tech job description and competency check list which was signed by the staff member and his or her supervisor. The Paramedic Tech job specification requires basic life support, Emergency Medical Technician certification, and to assist the Paramedic. The Paramedic Tech Job competency checklist does not have Endotracheal Intubation, Intravenous canalization for the purpose of initiating a patient IV line, the required essential functions listed on the competency checklist for the staff member to be annually evaluated for performing as a Paramedic.</p> <p>2. At 2:30 PM on 11/30/2011, staff member #63 indicated that staff member #66 was a Paramedic and should of</p>		<p>essential functions and competency checklists for a Paramedic. 2. When supervisors are provided their monthly list of employees who need to be evaluated, they will be given a reminder to verify that the employee is being evaluated using the correct evaluation form for the employee's assigned job position. This will include the correct job description, essential functions and competency checklists. When supervisors submit employee evaluations to the Human Resources Department as final, Human Resources will verify that the correct evaluation form was used in the evaluation before the evaluation is accepted as final and complete in Human Resources. 3. The supervisor completing the employee evaluation and the Administrative Director of Human Resources will be responsible for number 1 and 2 above. The deficiency will be corrected by December 23, 2011</p>		

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S0554	<p>received a job description and competency checklist for a Paramedic. The staff member #63 confirmed staff member #66 personnel files do not have any other competency checklist and job description in it except a Paramedic Tech competency checklist which was not the correct one for the staff member to receive and sign. Staff member #63 confirmed that Paramedic staff member #66 was evaluated for a Paramedic Tech. Staff member #63 indicated that Paramedic staff member #66 performs the job requirements listed for a Paramedic working at Marion General Hospital. Staff member #63 indicated that staff member #66 was certified Paramedic; however, the staff member's job description, competency checklist, and annual evaluation did not reflect a person who is a certified Paramedic.</p> <p>410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review and staff interview, the facility failed to follow manufacturer's directions for dating supplies and chemicals and discarding to prevent outdated usage in 9</p>	S0554	<p>Item # S 554; #1 Informational Item # S 554; #2 1. Corrected on 11/30/11, Test strips and protective equipment were delivered to the ultrasound department for handling of MetriCide. All MetriCide in use is</p>	12/22/2011	

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	<p>areas (surgery, central supply, medical oncology, emergency department, med/surg, family birthing center, pediatrics, short stay observation and ambulance garage).</p> <p>Findings included:</p> <p>1. Cidex OPA manufacture sheet requires: 1) The user should be adequately trained in the demonstration and disinfection of semi-critical medical devices and the handling of liquid chemical germicides, 2) Cidex OPA stored in it's original container 59 to 86 degrees Fahrenheit and is in a well-ventilated low traffic area, 3) Once opened, the unused portion of the solution may be stored in the original container up to 75 days until used, 4) Record the date the container was opened on the container label or in a log book, record the date the solution was poured outside the original container and the product must be used within 14 days, 5) Manual processing - Immerge device completely, filling all lumens and eliminating air pockets in Cidex OPA solution for a minimum of 12 minutes at 68 degrees F or higher 6) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use</p>		<p>now labeled for disposal after useful life. 2. Prevention will be controlled by monitoring of the ultrasound staff logs. 3. Accountability for this item will be handled by Administrative Director of Radiology. 4. Corrected on 11/30/11 Item # S 554; #3 & 41. Discarded outdated, discolored/ faded/non-legible items as well as bent guide wires. Supply room was re-organized assuring all supplies were not outdated. Guide wires now being stored in a long, straight container.2. Storeroom better organized for better visualization of supplies. Receiving & Distribution (R&D) will check dates daily when re-stocking. 3. Director of Emergency Medical Services and Manager of R&D 4. 11/30/11 Item # S 554; #5; #A 1. Discarded outdated items immediately on 11/30/11. 2. Check for outdates on a daily basis, with weekly focuses on items that do not move often. Unit Shift Manager (USM) of Operating Room (OR) and Administrative Director (AD) of Surgical Services will randomly check outdates. 3. USM of OR, AD of Surgical Services, and Inventory clerk. 4. Effective immediately 11/30/11. Item # S 554; #5; B 1. Discarded outdated items immediately on 11/30/11. 2. Upon opening of new product, department will use a darker, more legible marker to increase</p>				

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	<p>fresh water each time this step is done 7) test strips should be used each time before Cidex OPA is used to measure for the proper concentration 8) exhaust hoods are required when using Cidex OPA, 9) Use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns, and 10) the lids for the test strips and solution need to be tight fitting.</p> <p>2. At 2:30 PM on 11/28/2011, the Radiology Department was toured. The department had 2 ultrasound rooms and both were inspected. Neither ultrasound room had personal protective equipment (PPE) when handling Cidex OPA. Neither room had test strips to test the concentration according to the manufacturer's instructions. The solution in the holder on the wall was not dated reflecting the start/and or discard date of the solution.</p> <p>3. At 1:00 PM on 11/30/2011, the Ambulance Garage was inspected. The following items were observed out dated: 7 Blue Line Tracheal tube stylets expired 7/99, 2/97, 12/97, 7/98, 4/98, 8/99, and 10/01. Twelve Satin Slip guide wire for pediatric patients were bent out of shape to the point that the guide wire could not guide the tracheal tube as it was designed for. Approximately 40 other packages of patient health care supplies were faded to</p>		<p>the visibility of the expiration date. New visible date to be monitored by staff on a daily basis. 3. Director of Materials Management and Receiving and Distribution Manager 4. 12/1/11 Item # S 554; #5; #C, D & E 1. Deficiency corrected immediately on 11/30/11. Expired reagents discarded. 2. All Histotechs will check for outdates on a weekly basis. 3. Laboratory Manager will spot check the Frozen Section room monthly. 4. Corrected on 11/30/11 Item # S 554; #6 1. Product was properly disposed of immediately after discovery of expiration date on 11/28/11. 2. Through training, the staff will date the "opened product" expiration visibly on container after opening. This product will be monitored on a weekly basis. 3. Director of Materials Management and Receiving/Distribution Manager. 4. 12/1/11 Item # S 554; #7; #A, B & C 1. Deficiency corrected immediately. Expired reagents discarded on 11/28/11. 2. Lab Scientist at Medical Oncology will check for outdates on a weekly basis. 3. Laboratory Manager will spot check reagent outdates monthly. 4. Corrected on 11/30/11. Item # S 554; #7; #D 1. We corrected this deficiency by discarding the two outdated glucometer test strips on November 30, 2011. 2. The glucometer has been given to a RN to monitor daily with review of</p>		

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	<p>the color yellow and the date faded to the point of not legible. Staff member #58 confirmed the medical supplies being out of date. The products are mixed in with products that was evident of being recently stocked.</p> <p>4. At 1:15 PM on 11/30/2011, staff member #58 indicated Central Supplies stock their inventory and it was evident to him or her that the old stock was not removed from inventory.</p> <p>5. During the tour of the surgical area at 10:20 AM on 11/28/11, accompanied by staff members #35 and #36, the following observations were made:</p> <p>A. Three of ten Insyte autoguard #24 gauge , 2 expired 08/2010, 1 expired 02/2011, in the supply room.</p> <p>B. Cidex OPA solution test strips with an expiration date of 11/01/11 in the clean room.</p> <p>C. Hematoxylin 1 with a written date of 12/18/09 and a manufacturer's expiration date of 06/2011 in the frozen section/tissue room.</p> <p>D. Rabbit serum monoclonal and mouse serum monoclonal with a written expiration date of 08/2010 in the frozen section/tissue room.</p> <p>E. Acetic acid glacial with a written expiration date pf 06/21/10 in the frozen section/tissue room.</p>		<p>glucometer test strips to assure that none are outdated. A log is set up to assure that an easy way to monitor the monitor and strips to prevent use of outdated strips.</p> <p>3. RN staff nurse assigned and Oncology Administrative Director is responsible to review the log monthly. 4. Corrected on 11/30/11 Item # S 554; #8, #A</p> <p>1. Discarded outdated containers Fastrack area 11/29/11. 2. The OC specimen containers will no longer be part of the stock for Fastrack. Staff educated in weekly Emergency Department (ED) Huddle 12/19 – 12/25/11. 3. Director of ED 4. 12/14/11 Item # S 554; #8; #B</p> <p>1. Outdated sutures were discarded and replaced on 11/29/11. 2. Trauma Room checklist updated to state "check sutures for expiration date." Staff educated in weekly Emergency Department (ED) Huddle 12/19 – 12/25/11. 3. Director of ED 4. 12/19/11 Item # S 554; #8; #C</p> <p>1. Vial was discarded on 11/29/11 2. Staff re-educated on requirement of dating glucometer strip vial upon opening and to discard after 180 days. Staff educated in weekly Emergency Department (ED) Huddle 12/19 – 12/25/11. 3. Unit Shift Managers of ED 4. 12/19/11 Item # S 554; #9</p> <p>1. These items corrected by removing outdated supplies (Culture Swabs) on 11/29/11. 2. Prevention will be controlled by constant monitoring of the nursing staff and education</p>		

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	<p>6. During the tour of the central supply area at 2:30 PM on 11/28/11, accompanied by staff members #38 and #41, the Wavicide test strips were observed with an open date of 02/01/11. Manufacturer's instructions were to discard within 120 days of opening.</p> <p>7. During the tour of the medical oncology facility at 3:35 PM on 11/28/11, accompanied by staff members #2 and #39, the following observations were made:</p> <p>A. Resolve microscope immersion with a manufacturer's expiration date of 08/08, in the office with the microscope.</p> <p>B. A 1000 milliliter bag of 0.9 Normal Saline intravenous solution with a manufacturer's expiration date of 1 April 2011, in a cabinet in the lab.</p> <p>C. Acetic acid with a written expiration date of 01/14/11 and acetone with a manufacturer's expiration date of 12/2010, in the flammable cabinet in the lab.</p> <p>D. A vial of glucometer test strips with a manufacturer's expiration date of 07/2011 and another vial with a written expiration date of 11/24/11, in a cabinet in the infusion area.</p> <p>8. During the tour of the emergency department at 8:50 AM on 11/29/11, accompanied by staff member #42, the</p>		<p>of staff. Education to staff scheduled electronically for 12/22/11. 3. Accountability for this item will be handled by Unit Manager of MedSurg. 4. Corrected on 11/29/2011 Item # S 554; #10 1. Destroyed undated bottle of strips. Opened new bottle and dated per policy. Posted policy by meter and added to agenda for discussion at staff meeting how to correctly date vial. 2. The charge nurse will either check dates on bottle nightly during Quality Check or will assign someone to do it. 3. Family Birthing Center Unit Manager 4. November 29, 2011 Item # S 554; #11; #A 1. Destroyed incorrectly dated bottle of strips. Opened new bottle and dated per policy. Posted policy by meter and added to agenda for discussion at staff meeting how to correctly date vial. 2. The charge nurse will either check dates on bottle nightly during Quality Check or will assign someone to do it. 3. Pediatrics Unit Shift Manager 4. November 29, 2011 Item# S 554; #11; B-C 1. Every item on the Braslow cart was removed and checked for expiration dates by Pediatrics Unit Shift Manager (USM). New items were ordered, expiration dates checked and items replaced in Braslow cart. 2. Assigned by Pediatric Administrative Director (AD) for USMs to check cart monthly for outdates and sign log. Pediatric AD has placed on</p>		

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	<p>following observations were made:</p> <p>A. Four of four OC light specimen containers with an expiration date of 10/2011, in a drawer in the private bay of Fast Track.</p> <p>B. Three of three 3-0 silk sutures with an expiration date of 07/10, three of four 5-0 black monofilament sutures with an expiration date of July 2011, and three of three 4-0 chromic sutures with an expiration date of 07/09, in the trauma room.</p> <p>C. A vial of glucometer strips, open, but not dated, with the glucometer device. Manufacturer's instructions were to discard within 180 days of opening.</p> <p>9. During the tour of the medical/surgical unit (5W) at 9:30 AM on 11/29/11, accompanied by staff members #43 and #44, a BBL culture swab with an expiration date of 09/2011, in an unlocked nurse server in room 592.</p> <p>10. During the tour of the family birthing center at 10:25 AM on 11/29/11, accompanied by staff members #45 and #46, a vial of glucometer strips, open, but not dated, were observed with the glucometer device. Manufacturer's instructions were to discard within 180 days of opening.</p> <p>11. During the tour of the pediatric</p>		<p>her calendar to check log and select items on the cart for validation on 1 st day of each month. 3. Pediatrics USM with validation by Pediatric AD. 4. November 29, 2011 Item # S 554; #12; A & B 1. Removed outdated defibrillator pads and dated vials of glucometer strips correctly. 2. Daily review of crash cart log by Staff RN. Short Stay Observation Unit Manager (SSO UM) will develop a check list guideline for glucometer vial monitoring and placed in Unit Shift Manager's resource folder. 3. Accountability for this item will be handled by SSO UM. 4. Corrected on 11/29/2011 Item # S 554; #13 1. Policy POC-108. Statement added "when new vial of Controls are opened, write Discard date on vial as 90 days from date you open the vial. Example, a control vial opened on January 1 would have a discard date of April 1." When a new vial of Strips is opened, write Discard date on vial as 180 days from date you opened the vial. Example, a vial opened on January 1, will be discarded on May 30. 2. Updated policy posted online. Policy now agrees with online competency and competency is checked after 6 months for new employees and annually thereafter. 3. Laboratory Point of Care Coordinator. 4. December 15, 2011</p>		

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	<p>department at 11:35 AM on 11/29/11, the following observations were made:</p> <p>A. Open, but not dated, vials of glucometer strips with the glucometer devices. Manufacturer's instructions were to discard within 180 days of opening.</p> <p>B. Two of two 20 gauge Insyte autoguard with an expiration date of 10/2011, in the yellow drawer of the Braslowe cart.</p> <p>C. Two of two 20 gauge Insyte autoguard with an expiration date of 10/2011, in the blue drawer of the Braslowe cart.</p> <p>D. Two of two 20 gauge Insyte autoguard with an expiration date of 10/2011, in the orange drawer of the Braslowe cart.</p> <p>E. Two of three 20 gauge Insyte autoguard with an expiration date of 10/2011, in the green drawer of the Braslowe cart.</p> <p>F. One of two cuffed tracheal tube with an expiration date of 09/2011, in the green drawer of the Braslowe cart.</p> <p>G. In the gray drawer of the Braslowe cart, 2 of 2 purple-top lab tubes with an expiration date of 08/2011, 1 of 1 red-top lab tube with an expiration date of 08/2011, 1 of 1 blue-top lab tube with an expiration date of 09/2011, 1 of 1 green-top lab tube with an expiration date of 05/2011, 2 of 2 yellow microtainers with an expiration date of 05/2011, and 1 of 1 lavender microtainer with an expiration date of 07/2011.</p>				

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	<p>12. During the tour of the short stay observation unit at 2:20 PM on 11/29/11, accompanied by staff member #49, the following observations were made:</p> <p>A. A package of defibrillator pads with an expiration date of 04/2004, on the crash cart.</p> <p>B. Open, but not dated, vials of glucometer strips with the glucometer devices. Manufacturer's instructions were to discard within 180 days of opening.</p> <p>13. At 9:50 AM on 11/30/11, staff member #55 presented the computer based training the staff received for the glucometer. The training indicated the strips were stable for 180 days and both the open date and discard date were to be written on the vial. The training also indicated both the open date and discard date were to be written on the control solution vials which were to be discarded after 90 days. Staff member #55 indicated staff was told to use 90 days as a discard date for both the strips and the controls to avoid confusion.</p>				

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S0592	<p>410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on observation and document review, the facility failed to ensure sanitation was maintained for Pathology and the Morgue.</p> <p>Findings included:</p> <p>1. Environment of Care Management Program Safety Management Plan states, "The program also assures compliance with all applicable local, state, and federal codes and regulations."</p> <p>2. OSHA regulation 1910.106(e)(9)(i) for</p>	S0592	<p>Item# S 592; #1 & 2 Informational Item# S 592; #3 1. Shelf liners replaced. 2. Staff instructed to clean spills/leaks as it occurs. 3. Laboratory Manager will periodically observe flammable cabinet for chemical leaks/spills. 4. Corrected December 6, 2011 Item# S 592; #4 Informational Item # S 592; #5 1. Morgue cleaned, trash emptied, plastic tubing under hand sink discarded, silicone tubes in body refrigerator discarded, and hand sanitizer installed near exit door. 2. Histotechs instructed to check cleanliness of morgue daily when</p>	12/23/2011

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	<p>the handling of chemicals states, "General maintenance and operating practices shall be in accordance with established procedures which will tend to control leakage and prevent the accidental escape of flammable or combustible liquids. Spills shall be cleaned up promptly."</p> <p>3. At 1:00 PM on 11/29/2011, the Pathology Area of the Marion General Hospital Laboratory was toured. The up-right tall two-door yellow flammable cabinet was inspected in the area. The shelves of the cabinet were observed with spills from assorted chemicals that were stored on the shelves.</p> <p>4. Department of Pathology, Procedure to Clean MGH Morgue, states, "Purpose: To maintain the morgue, clean and ready for use. Trash is to be bagged and dirty linen taken to soiled linen area of the Environmental Services Department. Check refrigerator drawers and clean if empty, if not empty, return later to complete cleaning."</p> <p>5. At 1:45 PM on 11/29/2011, the Marion General Hospital Morgue was inspected. The trash can adjacent to the handwashing sink was observed with trash in it and overfilled. The cabinet area under the handwashing sink was observed with heavy accumulation of rust and other soil</p>		<p>recording temperature of body cooler. Also instructed to notify environmental services (EVS) when autopsy completed so they will know to clean after procedure. Histotechs instructed to note on temperature chart when EVS notified of need to clean morgue. 3. Lab Manager will spot check cleanliness of morgue and review log monthly for documentation. A) Cleanliness and log sheets corrected December 1, 2011. B) Cabinet will be replaced by a stainless steel cabinet, which has been approved by Administration. 31-60 days: On order 61-90 days: Cabinet received and installed. Item # S 592; #6 1. Deficiency corrected immediately and tubing removed and discarded on 11/29/11. 2. Current process already established to place tools in dishpan and transported to Central Sterile for cleaning. 3. Laboratory Manager is responsible for checking morgue. 4. Issue resolved effective 12-1-2011.</p>		

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	<p>debris on the inside surfaces. Plastic tubing that was observed connected to the hand sink faucet was observed leading to under the sink basin and not connected to anything. The tubing was observed heavily soiled. The shakable 2-body refrigerated unit was observed with 2 silicone tubes on the inside of the refrigerator unit on the floor.</p> <p>6. At 1:00 PM on 11/29/2011, staff member #40 indicated the tubing under the hand sink was an old connection to Klemsine; however, the hospital does not clean the tools in the hand sink anymore, the tools are placed in another container and taken to another area in the hospital to be cleaned.</p>				

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S0594	<p>410 IAC 15-1.5-2(f)(3)(D)(ii)</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>(ii) Universal precautions, including infectious waste management.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure biohazard waste was handled according to hospital's policy for Marion General Hospital (MGH) Diagnostic Northwood.</p> <p>Findings included:</p> <p>1. The MGH Diagnostic - Northwood was toured at 10:09 AM on 11/29/2011. Draw Room #1 was observed with a red sharps container filled past the marked filled line on the container. One used needle was observed hanging out of the top of the container. The laboratory in MGH Diagnostic-Northwood was observed storing a filled red sharp's container on the floor next to the laboratory stand-up refrigerator.</p>	S0594	<p>Item # S 594: #1</p> <p>1. Deficiency corrected immediately; sharps container closed and secured and moved to locked storage area outside rear exit door of building 11/29/11.</p> <p>2. Staff educated on biohazard policy and instructed to lock/secure sharps containers when ¾ full and to move from lab area to secured storage area for pick up by contracted service (Stericycle).</p> <p>3. Laboratory manager will check during weekly rounding that policy is followed.</p> <p>4. Effective 11-30-11.</p> <p>-</p> <p>Item # S 594: #2</p> <p>-</p> <p>Informational</p> <p>Item # S 594: #3</p> <p>1. Miscommunication corrected with Northwood staff.</p> <p>2. Discussed during management staff meeting. Locked storage area</p>	12/19/2011	

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	<p>2. Housekeeping Procedures Waste Handling Needle Box Handling Procedure 8.04 states, "Sharps Containers (non-wall mounted) when 3/4 full, secure opening to prevent the container from being overfilled. The locked/secured needle container shall be transported to the soiled utility room. Environmental service personnel will routinely pick up sealed sharps containers from the soiled utility rooms. All used sharps containers will be handled as infectious waste. Sharp containers will be transported directly to the infectious waste staging area, and shall be disposed of according to facility procedure."</p> <p>3. At 10:30 AM on 11/29/2011, staff member #29 indicated the department does not have a soiled utility room for biohazard containers.</p>		<p>for biohazard trash behind the building is "soiled utility room".</p> <p>3. Laboratory manager will observe for compliance in biohazard storage.</p> <p>4. Effective 12-19-11</p>		

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S0596	<p>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 observation, document review, and staff interview, the facility failed to properly clean/disinfect the two Cryostat machinery located in Pathology and in Surgery.</p> <p>Findings included:</p> <p>1. At 1:00 PM on 11/29/2011, the Laboratory Department was toured. The department had 1 cryostat machine to test tissue samples. The cryostat machine was inspected and loose bloody tissue was observed on the inside.</p> <p>2, At 10:35 AM on 11/30/2011, staff member #40 indicated the Cryostat machines are disinfected semi-annually. However, the staff member reviewed the disinfecting log and noticed the</p>	S0596	<p>Item # S 596; # 1 1. Specimen still in Cryostat when inspector toured Pathology department. Processing completed and Cryostat cleaned within minutes of tour. 2. Histotechs instructed to follow policy and clean cryostat after each specimen. 3. Laboratory Manager will observe for compliance. 4. Effective 11-29-11 Item # S 596; # 2 1. Histotechs instructed to follow policy and document semi-annual maintenance and repairs as completed on established maintenance log. 2. Maintenance logs will be reviewed quarterly. 3. Laboratory Manager will observe for compliance. 4. Effective 11-29-11 Item # S 596; # 3 Omitted Item # S 596; # 4 Informational Item # S 596; # 5 1. Histotechs instructed to follow policy and document cleaning after each use on established log</p>	11/30/2011			

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	<p>documentation did not reflect semi-annual cleaning.</p> <p>4. The Leica Microsystems Cryostat machine manufacturer manual states, "Surfaces which are potentially contaminated (infectious germs) should always be cleaned with alcohol disinfectants." The manufacturer's manual requires the machine to be disinfected after being exposed to contamination.</p> <p>5. The Pathology Equipment and Repair Record records for disinfection of the two cryostat machines were reviewed with staff members #41 and #53 at 10:35 AM on 11/30/11. The documentation that was provided revealed the unit stored in the Histology Section Department in Surgery had its last preventive Maintenance on 10/29/2009 and that was the last recorded day the unit was decontaminated. The documentation that was provided revealed the unit stored in the Laboratory Department had it's last decontamination on 8/16/2011. The facility could not provide a cleaning schedule of the two cryostat units. The facility could not provide documentation when the two units were used.</p> <p>6. The hospital's policy, Disinfection and Cleaning of Cryostat , states The cryostat</p>		<p>sheet. Histotechs instructed to perform and document semi-annual disinfectant on maintenance log. 2. Daily Log sheet will be reviewed monthly. Cryostat Maintenance logs will be reviewed quarterly. 3. Laboratory Manager will observe for compliance. 4. Effective 11-29-11 Item # S 596; # 6 Informational</p>		

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	is a refrigerated chamber containing a miacrotome cooled by a mechanical refrigeration unit. The cryostat must be kept free of tissue debris that remains from frozen sections, thus removing any infectious hazards. All debris found in the chamber must be removed after each use with gauze dampened with 70% alcohol. Discard in a biohazard bag. Defrost and clean the cryostat frequently, disinfecting the unit if indicated. Record the procedure in the Histology Maintenance logbook"				

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S0610	<p>410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure kitchen staff are washing hands as required by Retail Food Establishment Sanitation Requirements and hospital policies for kitchen/cafeteria and failed to ensure all refrigerators were monitored according to policy in the obstetrical department.</p> <p>Findings included:</p>	S0610	<p><u>Item # S 610; #1, 2, 3, 5 & 6</u></p> <p>Informational</p> <p><u>Item # S 610; # 4 & 7</u></p> <p>1. The deficiency is corrected by training and/or retraining employee's adherence to the infection control policies and procedures.</p> <p>2. The deficiency will be prevented from occurring in the future by monitoring the employee's</p>	11/30/2011			

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	<p>1. Environment of Care Management Program Safety Management Plan states, "The program also assures compliance with all applicable local, state, and federal codes and regulations."</p> <p>2. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After caring for or handling service animals or aquatic animals as specified in section 116(b) of this rule; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section 113(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with</p>		<p>adherence to the infection control policies and procedures by observing employee's practices, monitor the completion of temperature logs and conducting quarterly food safety audits.</p> <p>3. The person responsible to ensure the deficiencies are corrected are Director of Nutritional Services; Clinical Nutrition Manager; Executive Chef; and the supervisors.</p> <p>4. All of the deficiencies were corrected on November 28, 2011.</p> <p>Item # S 610: #8, 9 & 3</p> <p>1. Family Birthing Center Administrative Director assigned Charge Nurse in Nursery to do temperature checks on breast milk, meconium and employee refrigerators or assign someone to do it. Medication refrigerator is being monitored by Pharmacy and a log is kept there. Therefore Medication Refrigerator log in the nursery has been discontinued.</p> <p>2. Shifting responsibility from Patient Care Assistant (PCA) to Nurse due to PCA not always being in nursery while there is always a Nurse in the nursery.</p> <p>3. Family Birthing Center Unit Manager</p> <p>4. Corrected 11/29/11</p>	

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	<p>ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands."</p> <p>3. Marion General Hospital Dietary Sanitation and Infection Control Policy states, "In the Food & Services Department: All employees associated with the handling of food shall wash hands. Hands are washed with soap and water at he following times: Before each shift, Before handling food or clean utensils/dishes/equipment, Before putting on gloves,</p> <p>4. At 11:30 AM on 11/28/2011, Marion General Hospital kitchen/cafeteria was toured. A staff member working in the cafeteria on the hot bar was observed touching non-food surfaces with his/her gloved hands and then handled single-use clam shell food containers with the same gloved hands. The staff member was observed handling a wiping cloth with his/her gloved hands and again handled food contact surfaces without washing hands and changing gloves. When the staff member did change the gloves, the staff member did not wash his/her hands between changing of gloves. The staff member working the grill station in the</p>				

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	<p>cafeteria was observed changing his/her gloves without washing hands between the changing of gloves.</p> <p>5. Retail Food Establishment Requirements 410 IAC 7-24-187, Potentially Hazardous Food; Hot and Cold Holding states, " Potentially hazardous food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above; At forty-one (41) degrees Fahrenheit or less."After handling garbage, after removing gloves, after any other activity that may contaminate the hands."</p> <p>6. Marion General Hospital Dietary policy, Storage Temperatures, states, "Holding potentially hazardous foods at temperatures of 140 degrees F. or greater or 41 degrees F. or less."</p> <p>7. The following items in the salad bar were above the required cold holding temperature of 41 degrees F: cottage cheese 45 F, chopped eggs 45 F, and Bean salad 54 F, The temperatures were taken by the Foodservice Director with his digital thermometer, The cold holding kiosk located by the deli station was inspected. All the potentially hazardous food ranged between 50 and 55 F when the law requires all food for cold holding be 41 F or less. The food items included:</p>				

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	<p>chicken tossed salad, roast beef sandwich, white and chocolate milk, chicken salad, yogurt, etc. The temperatures were confirmed with the Food Service Director.</p> <p>8. During the tour of the obstetrical department at 10:30 AM on 11/29/11, accompanied by staff members #45 and #46, four refrigerators (breastmilk, meconium, employee, and medication) were observed in the nursery area. The temperature monitoring logs were reviewed and the September 2011 log lacked documentation of any checks for 14 days, the October 2011 log lacked documentation of any checks for 11 days, and the November 2011 lacked documentation of any checks for 10 days.</p> <p>9. The facility policy titled "Refrigerator/Freezer Temperature Monitoring", last revised 04/25/11, indicated, "All Hospital owned refrigerators and freezers shall be monitored to ensure the temperature is maintained to set criteria and appropriate action is taken in the event of a temperature failure."</p> <p>3. At 10:40 AM on 11/29/11, staff members #45 and #46 confirmed the lack of daily checks of the refrigerators for the last 3 months.</p>				

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S1022	<p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation, document review and staff interview, the facility failed to secure the ambulance as the secondary lock of controlled substances stored on the ambulance.</p> <p>Findings included:</p> <p>1. Medications Narcotic Lock and Key System policy #Nur-614 states, "All scheduled II narcotic and controlled medications must be kept under double lock at all times."</p> <p>2. Handling of Medications Used in the Ambulance Department, Emergency Medical Services policy #EMS-221 states,</p>	S1022	<p><u>Item # S 1022; #1</u></p> <p>Informational</p> <p><u>Item # S 1022; #2</u></p> <p>Informational</p> <p><u>Item # S 1022; #3</u></p> <p>Informational</p> <p><u>Item # S 1022; #4</u></p> <p>1. Require all doors on ambulances in service (with narcotics onboard) be locked when not in use.</p> <p>2. Update policy to state that all ambulances that are in service will have all doors locked when not in use with keys placed on key holder in main office or remain with personnel assigned to truck. Do random checks for locked doors and hold</p>	12/23/2011

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	<p>"The authority to enforce drug use and control policies and procedures comes from the hospital administration, with endorsement of medical staff, via the Pharmacy and Therapeutics Committee. Proper handling of and accountability for drugs used is responsibility of the Ambulance Service personnel."</p> <p>3. Emergency Medical Services, Securing all Ambulances policy EMS-230 states, "All MGH ambulances will be locked or secured. The ambulances will have the keys removed from the ignition and placed on the key holder in the main office."</p> <p>4. At 2:01 PM on 11/29/2011, the ambulance garage bay door off of the Emergency Department entrance was observed unlocked and the side and rear doors of the ambulance in the garage were unlocked. At 1:00 PM on 11/30/2011, again the garage door was kept unlocked and all ambulance doors were unlocked. The keys to the ambulance were left on the console between the two front seats. Neither inspection, a staff member was present in the ambulance garage bay.</p> <p>5. At 2:00 PM on 11/30/2011, staff member #57 indicated the narcotics and controlled substances are provided to the EMS staff and are expected to secure the</p>		<p>Emergency Department (ED) staff accountable.</p> <p>3. ED Director, ED Unit Shift Managers</p> <p>4. 12/23/11</p> <p>Item # S 1022; #5</p> <p>-</p> <p>1. Require all doors on ambulances in service (with narcotics onboard) be locked when not in use.</p> <p>2. Assure all ambulances have 2 sets of keys for cab door and doors on patient compartment that work. Do random checks for locked doors and hold staff accountable.</p> <p>3. ED Director, ED Unit Shift Managers</p> <p>4. 12/23/11</p> <p>Item # S 1022; #6</p> <p>1. Require all doors on ambulances in service (with narcotics onboard) be locked when not in use.</p> <p>2. Do random checks for locked doors and hold staff accountable.</p> <p>3. Emergency Department (ED) Director, ED Unit Shift Managers</p> <p>4. 12/23/11</p>		

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S1024	<p>ambulance as meeting the double lock requirement of the hospital on controlled medications.</p> <p>6. At 3:15 PM on 11/30/2011, staff member #3 indicated the ambulance should be locked when not in active use to secure all supplies and medications that are stored on the ambulance.</p> <p>410 IAC 15-1.5-7 (d)(2)(C)</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>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure multidose medication vials were dated and discarded to prevent outdated use.</p> <p>Findings included:</p> <p>1. During the tour of the out-patient</p>	S1024	<p>Item # S 1024; #1</p> <p>1. Educated all staff on proper procedure with one on one discussion. One time medications will be discarded as soon as used. Multi-dose medications will be labeled with date of expiration. All staff reminded how to discard medications and to label any reusable medication.</p>	12/27/2011	

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	<p>surgical area at 10:30 AM on 11/28/11, accompanied by staff member #35, a 50 milliliter vial of Xylocaine, open, but not dated, was observed sitting on the counter.</p> <p>2. During the tour of the recovery area at 1:25 PM on 11/28/11, accompanied by staff members #35 and #37, two open vials of insulin were observed in the medication refrigerator. The vial of Novolin R had no date on the bottle, but the box indicated a marking of 05/9. The vial of Novolog had an open date of 5/6/11 on the box. The manufacturer's directions for both vials were to discard 28 days after opening.</p> <p>3. During the tour of the Short Stay Observation unit at 2:30 PM on 11/29/11, accompanied by staff member #49, an open, but not dated vial of Tubersol for TB testing was observed in the medication refrigerator. The manufacturer's directions were to discard 30 days after opening.</p> <p>4. During the tour of the radiology department at 3:05 PM on 11/29/11, accompanied by staff member #60, an open, but not dated, half empty vial of Lidocaine and an open, but not dated, vial of Sodium Bicarbonate were observed on a cart. Staff member #60 indicated the</p>		<p>2. Post Anesthesia Care Unit (PACU)/Amb Surg Unit Shift Manager (USM) and Surgical Administrative Director (AD) will randomly make rounds to assure that multi-use medications are labeled or discarded if a one-time use.</p> <p>3. PACU/Amb Surg USM and Surgical AD and all staff are responsible.</p> <p>4. Effective immediately 11/30/11</p> <p><u>Item# S 1024; #2</u></p> <p>1. Discussed with Director of Pharmacy, techs will check outdates 2. Pharmacy techs will check outdates on all medications in Pyxis monthly 3. Post Anesthesia Care Unit (PACU)/ Amb Surg Unit Shift Manager (USM) will look at monthly reports from pharmacy techs, Surgical Administrative Director will assure that techs check outdates 4. Effective immediately 11/30/11</p> <p><u>Item # S 1024; # 3</u></p> <p>1. This was corrected by dating vial after investigation and information received from Pyxis for correct date. 2. Prevention will be controlled by constant monitoring by nursing and Pharmacy 3. Accountability for this item will be handled by Director of Pharmacy 4. The deficiency was corrected on the day the survey was conducted – 11/29/2011.</p> <p><u>Item # S 1024; # 4</u></p> <p>1. The lidocaine and sodium</p>		

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	<p>vials should have been thrown away after the procedures not left on the cart for reuse.</p> <p>5. The facility policy titled "Infection Controls/Safety Procedures Medication Vial Ampule Guidelines", last reviewed 01/10, indicated, ..."2. Multiple Dose Container- A multiple dose container will be used and stored after initial entry according to the manufacturer's guidelines. ...Manufacturer's expiration dates on multiple dose containers apply to properly stored, unopened or un-entered containers. Beyond use dating for opened or entered (e.g. needle punctured) multiple dose containers is 28 days per USP, unless otherwise specified by the manufacturer."</p> <p>6. At 1:25 PM on 11/30/11, the pharmacist, staff member #57, indicated the facility did not use many multidose vials, but the ones used should be dated and discarded 28 days after opening.</p>		<p>bicarbonate was discarded upon discovery.</p> <p>2. Prevention will be controlled by constant monitoring of the ultrasound staff</p> <p>3. Accountability for this item will be handled by Administrative Director of Radiology.</p> <p>4. Corrected on 11/30/11</p> <p>Item # S 1024: # 5</p> <p>Informational</p> <p>-</p> <p>Item # S 1024: # 6</p> <p>1. The nursing staff will be re-educated on policy NUR-621 that addresses the Multiple Dose Container - "A multiple dose container will be used and stored after initial entry according to the manufacturer's guidelines. Prior to use, personnel should visually inspect all product packaging for integrity of the manufacturer's seal, labeling, clarity of contents, and expiration date. Manufacturer's expiration dates on multiple dose containers apply to properly stored, unopened or un-entered containers. Beyond use dating for opened or entered (e.g., needle-punctured) multiple dose containers is 28 days, unless otherwise specified by the manufacturer."</p> <p>2. Pharmacy technicians will check any open multiple dose vials for dates on a monthly basis and discard any vials that are outdated.</p> <p>3. The Director of Pharmacy will send out a memo to the employees in any area where multiple dose vials are used to remind them of policy NUR-621 and tell them the pharmacy technicians will be auditing the open multiple dose vials for outdates and</p>		

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S1026	<p>410 IAC 15-1.5-7 (d)(2)(D)</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>(D) Documentation and accountability for an accurate accounting of controlled substances from the time of receipt in the institution through the administration to the patient or subsequent removal from general stock and reporting of all abuses and losses of controlled substances.</p> <p>Based on observation, document review, and interview, the facility failed to ensure a controlled substance was stored and disposed of according to standards of practice.</p> <p>Findings included:</p> <p>1. During the tour of the out-patient surgical department at 10:30 AM on 11/28/11, accompanied by staff member #35, a syringe with approximately 1 milliliter of clear fluid was observed taped inside an unlocked cabinet door. The syringe was secured with a piece of silk</p>	S1026	<p>discard any of those that are outdated</p> <p>4. December 27, 2011</p> <p><u>Item # S 1026: #1 & 2</u></p> <p>1. Deficiency corrected immediately. All staff talked to individually to make sure that they waste controlled substances as soon as they are done administering the medication. If they are alone on the unit they should call their direct supervisor, or the nursing supervisor to waste medication.</p> <p>2. All staff aware of procedure to waste medications.</p> <p>3. Post Anesthesia Care Unit (PACU)/Amb Surg Unit Shift Manager (USM) and Surgical Administrative Director will randomly make rounds to assure that medications are wasted.</p> <p>4. Effective immediately 12/01/11</p>	12/01/2011	

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	<p>tape with "Versed 1/1m" written on the tape.</p> <p>2. After questioning staff in the area at 10:35 AM on 11/28/11, staff member #35 indicated the nurse was waiting to waste the medication with another staff member, but indicated the storage was not according to policy.</p> <p>3. The facility policy regarding "Medication Distribution Controlled Drugs Used in the Anesthesia/Surgical Department" indicated, "The pharmacy is responsible for the accountability, security, and distribution of controlled substances used by the Anesthesia/Surgery Department." The policy specified Fentanyl and described the medication being under constant control of the anesthesiologist and the process for signing and wasting the medication.</p> <p>4. At 1:25 PM on 11/30/11, the pharmacist, staff member #57, indicated the policy referred to the other medications used in the surgical department, not just Fentanyl. He/she confirmed the facility's policy and standard of practice were not followed with the storage of the Versed.</p>		<p>Item # S 1026; #3</p> <p>Informational</p> <p>Item # S 1026; #4</p> <p>-</p> <ol style="list-style-type: none"> 1. Deficiency corrected immediately. All staff talked to individually to make sure that they waste controlled substances as soon as they are done administering the medication. If they are alone on the unit they should call their direct supervisor, or the nursing supervisor to waste medication. 2. All staff aware of procedure to waste medications. 3. Post Anesthesia Care Unit (PACU)/Amb Surg Unit Shift Manager and Surgical Administrative Director will randomly make rounds to assure that medications are wasted. 4. Effective immediately 12/01/11 		

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S1118	<p>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, document review, and staff interview, the facility failed to ensure the facility maintain sanitary and safe environment for Pathology, Housekeeping, Engineering, Dietary, Medical Oncology Building, and the Morgue and failed to ensure the staff's safety in the clean and soiled instrument rooms in the surgical department and in the frozen section room.</p> <p>Findings included:</p> <p>1. Environment of Care Management Program Safety Management Plan states, "The program also assures compliance with all applicable local, state, and federal codes and regulations."</p> <p>2. Infection Control Policy and Procedure requires, "The goals of the infection control policy for Marion General Hospital to mandate standard precautions,</p>	S1118	<p><u>Item # S 1118; # 1</u></p> <p>Informational</p> <p><u>Item # S 1118; #2</u></p> <p>Informational</p> <p><u>Item # S 1118; #3</u></p> <p>Informational</p> <p><u>Item # S 1118; #4</u></p> <p>1. All items have been removed from around the eye wash station, the station is now easily accessible, plus the basin has been thoroughly cleaned.</p> <p>2. Prevention will be controlled by constant monitoring.</p> <p>3. The responsible party for this item is the Director, Plant Engineering</p> <p>4. The deficiency was corrected on the day the survey was conducted – 11/28/2011.</p> <p><u>Item # S 1118; #5</u></p> <p>Informational</p> <p><u>Item # S 1118; #6</u></p>	12/15/2011

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	<p>treating body fluids, and other materials as if infectious and emphasizing, engineering and work practice controls as mandated by Marion General Hospital, Indiana Public Laws, CDC recommendations, Indiana Department of Health regulations, OSHA/IOSHA rules."</p> <p>3. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>4, The Engineering Department was toured at 2:01 PM on 11/28/2011. The plumbed eye-washing station next to the utility sink was observed with a mop bucket in front of it. Chemicals and other maintenance supplies were observed obstructing the eye-washing station</p>		<p>1. The deficiency was corrected by removing the fan and cart from obstructing the fire doors. 2. The deficiency will be prevented from occurring in the future by monitoring the fire doors during daily rounding. 3. The person responsible to ensure the deficiencies are corrected are Director of Nutritional Services; Clinical Nutrition Manager; Executive Chef; and the supervisors. 2. The deficiency was corrected on November 28, 2011.</p> <p><u>Item # S 1118; #7</u></p> <p>1. Educate and work with building (fire extinguisher) owner to fire law requirements to insure monthly inspections are consistently completed within time frame. 2. A protective services officer has been assigned the responsibility to make rounds in the oncology building to ensure fire extinguishers are being inspected in accordance with fire law. 3. Safety officer is responsible and will address any issues or deficiencies in a timely manner. 4. Effective immediately 12/15/11</p> <p><u>Item # S 1118; #8 & 9</u></p> <p>1. Place an eye washing station next to the Frozen Section (FS) and Central Sterile (CS) Rooms. 2. Have an eye washing station next to the Frozen Section and Central Sterile Rooms. 3. Administrative Director of Surgical Services, plant engineering 4. Deficiency corrected 12/07/2011 for FS room and 12/14/11 for the CS in Surgery Department.</p> <p><u>Item # S 1118; #10 & 11</u></p>		

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	<p>making it not accessible in case of immediate needs. The eye-washing station basin was caked in dirt and debris which gave the appearance of not being maintained.</p> <p>5. NFPA 101 7.5.1 states, "Exits shall be located and exits access shall be arranged so that exits are readily accessible at all times."</p> <p>6. The Dietary Department was toured at 11:00 AM on 11/28/2011. The warewashing area has two double fire exit doors exiting the room. The double doors are clearly marked with a ceiling mounted illuminated Fire exit sign. Both doors were observed obstructed. The Left door was obstructed with a 36" 5-foot tall pedestal fan while the right fire exit door was obstructed with an utensil storage cart.</p> <p>7. At 3:35 PM on 11/28/2011, the Medical Oncology building was toured. Two of two fire extinguishers were examined and the extinguishers have a monthly tag so when the extinguisher is inspected, the tag would be marked on the required spot. The Fire Extinguisher located at the entryway was observed only marked on the November spot and the other required months were not marked on the tag reflecting the possibility the fire</p>		<p>1. Installed eye washing station next to Frozen Section room</p> <p>2. Histotechs instructed on use of eye wash in the event of splash.</p> <p>3. Administrative Director of Surgical Services, plant engineering</p> <p>4. Corrected 12/7/11</p> <p>Item# S 1118; #12</p> <p>Informational</p>		

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	<p>extinguisher was not inspected in the previous months. The Fire Extinguisher located in the laboratory was observed with a line marked through from Jan , 2011 thru Oct 2011 then followed with initials on November. This gave the appearance that the fire extinguisher was not inspected appropriately according to the facility Fire Safety plan.</p> <p>8. During the tour of the surgical area at 1:55 PM on 11/28/11, accompanied by staff members #36 and #38, the sinks used for cleaning soiled surgical instruments were observed without any eyewashing devices.</p> <p>9. The labels on the Prolystica enzymatic cleaner and the Cidex OPA, 2 chemicals used in those areas, indicated the eyes should be flushed for 15 minutes if splashed with the chemicals.</p> <p>10. During the tour of the frozen section/tissue room in the surgical area at 2:20 PM on 11/28/11, accompanied by staff member #36, the lack of an eyewashing device was observed.</p> <p>11. The labels on 2 chemicals used in the frozen section/tissue room, Cytocool 11 and Hematoxylin 1, indicated the eyes should be flushed for 15- 20 minutes if splashed with the chemicals.</p>			

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	12. The facility's Safety Management Plan indicated, ..."The program also assures compliance with all applicable local, State, and Federal codes and regulations."			

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S1124	<p>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 observation, document review, and staff interview, the facility failed to comply with the Zoll M Series manufacturer's preventive maintenance requirements and maintain a defibrillator for Marion General Hospital's 6 ambulances.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Zoll manufacturer recommends checks and procedures to be performed on the defibrillator at the start of each shift. 2. The 2011 MGH Ambulance Department Schedule was reviewed. The 	S1124	<p>Item # S 1124; #1 Informational</p> <p>Item # S 1124; #2 Informational</p> <p>Item # S 1124; #3 Informational</p> <p>Item # S 1124; #4 1. We will purchase 2 moreZoll defibrillators to be prepared in the event of a disaster, this will give us 6 defibrillators for our 6 ambulances. We will obtain manufacturer's (Zoll) recommendations for checks and procedures to review for defibrillators. 2. Update check-off sheet & follow manufacturer's (Zoll) recommendations 3. Emergency Department Director 4. 12/23/11 to determine needs. We will be evaluating our budget needs by June 30 2012 and purchase the defibrillators by end</p>	12/23/2011	

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NAME OF PROVIDER OR SUPPLIER MARION GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 441 N WABASH AVE MARION, IN46952		
(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>Ambulance Department operates under three shifts and this was confirmed by staff member #58 at 12:30 PM on 11/30/2011.</p> <p>3. Emergency Medical Services Code D Major Plan Policy #EMS-209 states, "An assessment of each unit's equipment shall be conducted using the truck check-off sheet."</p> <p>4. The Ambulance Department operates 6 ambulances. The facility only has 4 defibrillators for the 6 ambulances. The MGS-EMS ALS Check-off lists were requested for the previous 7-day period. The Ambulance Department only provided documentation for 4 ambulances: #587, 425, 204, and 203. After reviewing the documentation provided, it could not be confirmed if all 4 defibrillators were being inspected at least once a day and definitely, the documentation revealed they were not being checked before each shift as required.</p>		of July 2012.		