

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2013
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/15/2013 through 10/17/2013</p> <p>Facility Number: 009443</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 10/23/13</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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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation, documentation review, and staff interview, the facility failed to ensure the Clean Linen Storage room was maintained clean and sanitary while storing the linen that was delivered by the contractor.</p> <p>Findings included:</p> <p>1. Environmental Service policy ENV032 (last approved 2/13/13) stated, "The following areas shall be cleaned on a daily basis, more often if needed: Clean Linen</p>	S000612	The shelving unit and the window sill in the Clean Linen Storage Room, was cleaned immediately on 10/16/2013 by the Environmental Service Manager. To ensure future compliance, the Environmental Service Manager provided education on cleaning this room to all Environmental Service employees. Verification of this education is maintained in the employee education files. This education was completed on 11/15/2013. On 11/1//2013, the Clean Linen Storage Room was added to the Environmental Service Tech's weekly cleaning schedule. On 11/1/2013, the Clean Linen Storage room was also added to the monthly Infection Control rounds which is completed by the Infection	11/15/2013			

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	<p>Room; Pharmacy; all auxiliary areas, all utility rooms, medication rooms, food preparation rooms, etc.."</p> <p>2. At 3:20 PM on 10/16/13, the Clean Linen storage room was toured with staff member #4. The window sill in the linen storage room was observed storing clean patient gowns on sticky substance that was on the window sill surface. The top metal shelves were observed heavily soiled with dust and other debris. The lower shelves that contained clean linen storage were observed dusty.</p> <p>3. At 3:25 PM on 10/16/2013, staff member #4 indicated the clean linen that is delivered by contractor will be stored in the Clean Linen Storage room. The staff member confirmed the room shelving unit's are dusty.</p>		<p>Control Officer or designee. The Infection Control Office or designee will document the compliance on the monthly Infection Control rounds and reported at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committees utilizing the formula: the denominator is the number of times the room was checked for cleanliness and the numerator is the number of times the room was found to be clean. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The Environmental Services Manager is ultimately responsible for the ongoing compliance of this regulation.</p>		

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S000748	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based on policy and procedure review, medical record review, and interview, the facility failed to ensure all entries in the medical records were authenticated and dated according to policy for 10 of 10 records of patients who received restraints during their hospitalization (#N3, N4, N5, N6, N9, N11, N12, N13, N14, and N19).</p> <p>Findings included:</p> <p>1. The facility policy "Documentation Standards", last reviewed Feb. 13, 2013, indicated, "10. Dating and Timing entries: A. All entries must be dated. B. Continental (military) time must be used in all entries. ...E. Each dated and timed entry must be followed by the signature or initials or the person making the entry."</p> <p>2. The facility policy "Restraints and Seclusion", last reviewed Feb. 13, 2013, indicated, "The initial assessment must be performed by physician, Licensed Independent Practitioner, or Registered</p>	S000748	<p>The Chief Nursing Officer reviewed Policy # DO5-G "Documentation Standards" and RO2-N "Restraints and Seclusion" with RNs during the clinical staff meeting on October 24, 2013. Verification of this education is maintained in the clinical monthly minutes. These policies will continue to be reviewed during the new hire orientation process by the Chief Nursing Officer. The Chief Executive Officer and the Medical Records Manager mailed letters to all attending physicians in order to re-educate them of this regulation which instructs them that all entries in the medical record must be dated, timed and authenticated. This was completed on November 15, 2013. On November 8, 2013, a reminder of this regulation was placed in the physician lounge and all dictation rooms. To ensure future compliance of this regulation, the House Supervisor will review 100% of restraint orders and re-educate any non-compliance with the individual employee. Also to assist in future compliance, the</p>	11/15/2013			

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	<p>Nurse. An initial assessment performed by the RN shall be reviewed by the physician and a physician's order is issued as indicated. The physician's order indicates agreement with assessment and the plan of care to use restraints. ...A written order, based on the examination of the patient by the MD/DO or LIP is entered into the patient's medical record on a daily basis when restraint use is clinically appropriate."</p> <p>3. The medical record for patient #N3 indicated "Restraint Order/Assessment Sheets", signed by the nurse at 0700 on 09/18/13, 09/19/13, 09/20/13, 09/21/13, 09/22/13, 09/25/13, and 09/26/13 that were signed by the physician, but not dated or timed to ensure a daily physician assessment. The record also contained another "Restraint Order/Assessment Sheet" that was not dated or timed by either the nurse or the physician.</p> <p>4. The medical record for patient #N4 indicated "Restraint Order/Assessment Sheet", signed by the nurse on 07/27, but with no time and with no date or time with the physician's signature. The record contained "Restraint Order/Assessment Sheets" signed by the nurse at 0700 on 08/10/13 and 08/18/13</p>		<p>Medical Records Manager will audit a minimum of 10 restraint orders for date, time and authentication of both the RN and the physician. The results of this audit will be reported at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committee by the Medical Records Manager utilizing the following formula: the denominator is the number of restraint days in the building and the numerator is the number of restraint days reviewed for date, time and authentication. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The Chief Nursing Officer is ultimately responsible for the ongoing compliance of this regulation.</p>				

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	<p>that were both signed by the physician at 1 PM on 09/24/13. Two other sheets were signed by the nurse at 0700 on 08/19/13 and 08/20/13, but lacked a date or time with the physician's signature. Another "Restraint Order/Assessment Sheet" lacked dates or times by either the nurse or the physician.</p> <p>5. The medical record for patient #N5 indicated "Restraint Order/Assessment Sheets", signed by the nurse at 0700 on 08/26/13, 08/27/13, 08/28/13, and 08/29/13 that were signed by the physician, but not dated or timed to ensure a daily physician assessment.</p> <p>6. The medical record for patient #N6 indicated "Restraint Order/Assessment Sheets", signed by the nurse at 0700 on 07/06/13 and at 1110 on 07/11/13 that were both signed by the physician at 8 PM on 07/17/13.</p> <p>7. The medical record for patient #N9 indicated "Restraint Order/Assessment Sheets", signed by the nurse at 0700 on 08/19/13, 08/20/13, 08/21/13, 08/22/13, and 08/23/13 that were signed by the physician, but not dated or timed to ensure a daily physician assessment.</p> <p>8. The medical record for patient #N11 indicated a "Restraint Order/Assessment</p>			

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	<p>Sheet", signed by the nurse at 0700 on 07/27/13 that was signed by the physician, but not dated or timed to ensure a daily physician assessment.</p> <p>9. The medical record for patient #N12 indicated a "Restraint Order/Assessment Sheet", dated at 0700 on 06/29/13, but without a nurse's signature, that was signed by the physician on 6/29, but without a time.</p> <p>10. The medical record for patient #N13 indicated a "Restraint Order/Assessment Sheet", signed by the nurse on 05/31, but without a time, that was signed by the physician, but without a date or time.</p> <p>11. The medical record for patient #N14 indicated "Restraint Order/Assessment Sheet", signed by the nurse on 06/16 and also signed by the physician on 06/16, but without times for either one. Two other sheets were both signed by the physician at 6:30 PM on 06/18/13, but lacked a nurse's signature, date, and time. The record contained "Restraint Order/Assessment Sheets" signed by the nurse at 0700 on 06/26/13, 06/27/13, 06/28/13, and 06/30/13 that were all signed by the physician at 2 PM on 07/11/13. Additional forms were signed by the nurse at 0700 on 06/24/13, 06/25/13, and 06/29/13 that were all</p>			

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S000936	<p>signed by the physician at 8 PM on 07/27/13.</p> <p>12. The medical record for patient #N19 indicated "Restraint Order/Assessment Sheet", signed by the nurse at 0700 on 09/19/13 and 09/22/13, that were signed by the physician, but without a time or time.</p> <p>13. At 3:00 PM on 10/16/13, the medical record findings were reviewed with staff members #P1 and P7 who confirmed the restraint order forms were not authenticated according to policy to ensure timely assessments.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities. Based on personnel file review, job description review, and interview, the facility failed to ensure 2 of 2 agency nurses met the RN (registered nurse) requirements (#A1 and A2).</p>	S000936	By November 14, 2013 all agency RNs were assigned to an ACLS class that was provided by Medical Staffing Solutions. Proof of current ACLS certification is maintained in the Agency Human Resource	11/15/2013	

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the personnel file for agency RN #A1, hire date 01/09/13, lacked documentation of competency in blood administration and documentation of current ACLS (Advance Cardiac Life Support). The personnel file contained a "Registered Nurse" job description. 2. Review of the personnel file for agency RN #A2, hire date 06/01/12, lacked documentation of competency in blood administration and documentation of current ACLS (Advance Cardiac Life Support). The personnel file contained a "Registered Nurse" job description. 3. The "Registered Nurse" job description listed all of the responsibilities of the nurse and indicated, "BLS [Basic Life Support] and ACLS required. Advanced cardiac life support certification required within twelve months of hire." 4. At 3:30 PM on 10/17/13, after checking with the agency, staff member #P1 indicated they did not require ACLS for their RNs and the blood competency education was the responsibility of the individual facilities. Agency nurse #A1 had not been with the facility for quite a year yet, but was not held to the ACLS 		<p>Files. To ensure ongoing compliance, The Human Resource Coordinator is ultimately responsible to ensure that agency employees maintain a current ACLS certification in order to work. She will communicate this information to the Scheduling Coordinator and Chief Nursing Officer. The Human Resource Coordinator will report the compliance rate of the agency nurse working with ACLS monthly to the QAPI meeting and to the quarterly OIC/MEC/GB until a 90% compliance rate is achieved and maintained for a minimum of 3 months. By November 15, 2013, all agency employees were educated on policy # BO4-N "Blood/Blood Components Administration (Packed Cells, Plasma, Platelets, Cryoprecipitate)". For future compliance, this policy has been added to the agency orientation packet so that they can be trained during their orientation process by the Chief Nursing Officer or designee. This education is maintained in the employee's education file.</p>		

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S001026	<p>requirement by the agency. Staff member #P1 indicated they did not have the agency RNs transfuse blood, but confirmed the agency nurses had the same job description as all of the other RNs instead of one specific to them.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 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, interview, and policy and procedure review, the facility failed to ensure staff followed their policy regarding controlled substances in 1 of 1 instances on an inpatient unit.</p> <p>Findings included:</p> <p>1. During the tour of the 4th floor</p>	S001026	On October 16, 2013, the Chief Nursing Officer issued a verbal disciplinary action to the nurse involved and reviewed policy "Automated Drug Cabinetry" regarding proper process for multi-dose and single-dose vials and correct protocol for narcotic wasting with the nurse involved. On October 24, 2013, the Chief Nursing Officer	11/01/2013

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	<p>inpatient unit at 10:20 AM on 10/16/13, accompanied by staff members #P1 and P7, nurse #P12 was observed in the hallway with a wheeled medication cart. Several open vials of insulin, dated appropriately, were observed in one drawer of the cart. In another drawer, an open, but not dated, single dose one milliliter vial of Hydromorphone (a controlled drug) was observed.</p> <p>2. At 10:30 AM on 10/16/13, nurse #P12 indicated he/she was just going to give a dose of the Hydromorphone to a patient who requested the medication every 2 hours. When questioned regarding the vial already being open, he/she indicated the dose was only half of a milliliter and he/she had given a dose from the vial earlier.</p> <p>3. At 10:40 AM on 10/16/13, the Director of Pharmacy, staff member #P6, indicated the automated drug cabinet would allow wasting of the unused portion of a controlled substance at the time of removal from the system or later. He/she indicated the vial should not be stored elsewhere and used again for a second dose.</p> <p>4. The facility policy "Automated Drug Cabinetry", last revised 01/2013, indicated, "9. Drugs that are refused by</p>		<p>reviewed policy "Automated Drug Cabinetry" with all RNs to review the proper process for multi-dose and single-dose vials and correct protocol for narcotic wasting. To ensure future compliance, On November 1, 2013 the House Supervisor began auditing 8 mobile medication carts a day to check multi-dose vials for appropriate dates and to verify that single dose vials are not being utilized as multi-dose. They also verify that any unused portion of a controlled substance has been disposed of according to policy. This audit will continue until a compliance rate of 90% is achieved and maintained for three months. The compliance rate will be reported to the OIC/MEC/GB by the Director of Quality Management utilizing the following formula: the numerator is the number of wheeled medication carts that were checked and the denominator is the number of mobile medication carts in the building. The Chief Nursing Officer is ultimately responsible for the ongoing compliance of this regulation.</p>				

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S001118	<p>patients, or are otherwise unneeded may be returned to the cabinet according to the following rules: a. Injectable controlled substances must be wasted. They may NOT be returned directly to the ADC. ...10. The unused portion of a controlled substance, or an unneeded injectable controlled substance must be wasted and the waste must be documented in the cabinet's computer."</p> <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 documentation review and observation, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (4) instances: Dialysis Pump room, 3rd floor Housekeeping Closet,</p>	S001118	The Dialysis Pump Room floor and brine tank were cleaned immediately on 10/16/13 by the Environmental Service Manager. The ceiling tiles were changed and the defective valve that caused the leak was repaired on 10/16/2013 by a Maintenance Mechanic. To ensure future compliance of the cleanliness of the Dialysis Pump Room, the Environmental Service Manager provided cleaning education of this	11/15/2013			

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	<p>Basement Laundry Room, and Basement Housekeeping Storage Room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Environmental Service policy ENV032 (last approved 2/13/13) stated, "The following areas shall be cleaned on a daily basis, more often if needed: Clean Linen Room; Pharmacy; all auxiliary areas, all utility rooms, medication rooms, food preparation rooms, etc.." 2. During the tour of the 4th floor at 10:00 AM on 10/16/13, accompanied by staff members #1 and #7, the Dialysis Pump Room was observed with the floor dirty and littered with bits of paper and debris. A towel was on the floor between the tanks, a cardboard box on the floor was stained and wet, and a four inch circular pool of water was on the top of the brine tank. At 1:15 PM on 10/16/13, the Dialysis Pump 		<p>room to all Environmental Service employees. This education was completed on 11/15/2013 and is maintained in the employee education file. On 11/1//2013, the Dialysis Pump Room was added to the Environmental Service Tech's weekly cleaning schedule. On 11/1/2013, this room was also added to the monthly Infection Control rounds which is completed by the Infection Control Officer or designee. The Infection Control Officer will document compliance on the monthly Infection Control rounds and report at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committees. The Environmental Service Manager is ultimately responsible to ensure the routine cleaning of this room. These audits will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The 3rd floor Housekeeping Closet sink basin, drain, and floor were cleaned immediately on 10/16/2013 by the Environmental Service Manager. To ensure future compliance of the cleanliness of the 3rd floor Housekeeping Closet, the Environmental Service Manager provided cleaning education of this room to all Environmental Service employees. This education was completed on 11/15/2013 and is maintained in the employee education files. On 11/1//2013, the 3rd floor</p>				

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	<p>Room was inspected with staff member #4. The ceiling tiles directly above the Brine Tank were observed with a yellowish stain. There was a continuous dripping of water on top of the Brine Tank leaving a pool of water settling on top of the tank.</p> <p>3. At 1:25 PM on 10/16/2013, the 3rd floor Housekeeping Closet was inspected with staff member #18. The mop sink was observed heavily caked with assorted debris on the inside basin. The sink drain was completely clogged with debris. The housekeeping floor was observed heavily soiled with pieces of paper and other loose debris. Two white plastic bags of clean rags were stored in direct contact of the dirty floor.</p> <p>4. At 3:00 PM on 10/16/13, the Basement Laundry Room was toured with staff member #4. The 2-bay hand washing sink was observed with loose debris on the inside of the sink basins. The</p>		<p>Housekeeping Closet was added to the Environmental Service Tech's weekly cleaning schedule. The Environmental Service Manager is ultimately responsible ensure the routine cleaning of this room. On 11/1/2013, this room was also added to the monthly Infection Control rounds which is completed by the Infection Control Officer or designee. Compliance will be documented on the monthly Infection Control rounds by the Infection Control Officer and reported at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committees. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The 2 bay hand washing sink basin and floor in the Basement Laundry Room were cleaned immediately on 10/16/2013 by the Lead Environmental Service Tech. To ensure future compliance of the cleanliness of the Basement Laundry Room, the Environmental Service Manager provided cleaning education of this room to all Environmental Service employees. This education was completed on 11/15/2013 and is maintained in the employee education file. On 11/1//2013, the 3rd floor Housekeeping Closet was added to the Environmental Service Tech's weekly cleaning schedule.</p>				

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	<p>floor was observed with loose pieces of paper and other debris on the floor.</p> <p>5. At 3:10 PM on 10/16/13, the Basement Housekeeping Storage Room was observed with staff member #4. The metal storage shelving was observed with a sticky substance on two of the metal shelves. Boxes of exam gloves were observed stored in direct contact with the sticky substance. When a box of gloves was removed from the shelf, the sticky substance was dripping from the bottom of the box.</p>		<p>The Environmental Service Manager is ultimately responsible ensure the routine cleaning of this room. On 11/1/2013, this room was also added to the monthly Infection Control rounds which is completed by the Infection Control Officer or designee. Compliance will be documented on the monthly Infection Control rounds and reported at the monthly Leadership meeting as well as the quarterly OIC/MEC/GB committees. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The shelving unit in the Basement Housekeeping Storage Room was replaced on 11/4/2013 by a Maintenance Mechanic. To ensure future compliance of the cleanliness of the Housekeeping Storage Room, the Environmental Service Manager provided cleaning education of this room to all Environmental Service employees. This education was completed on 11/15/2013 and is maintained in the employee education file. On 11/1/2013, the Housekeeping Storage Room was added to the Environmental Service Tech's weekly cleaning schedule. The Environmental Service Manager is ultimately responsible ensure the routine cleaning of this room. On 11/1/2013, this room was added to the monthly Infection Control rounds which is</p>		

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S001216	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii)(iii)(iv)(v)(C)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following:</p> <p>(A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control; (iv) technique charts, where applicable; and (v) handling of hazardous materials. (C) Appropriate storage, use, and disposal of radioactive materials.</p>		<p>completed by the Infection Control Officer or designee. The Infection Control Officer will document all fall outs on the monthly Infection Control rounds and reported at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committees. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months.</p>	

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	<p>Based on documentation review, observation, and staff interview, the facility failed to ensure proper safety precautions were maintained against radiation hazards in accordance with the hospital's radiation and safety program related to the Radiology Treatment Room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Radiation Protection Program policy RAD10 (last approved 2/13/2013) stated, "All employees will wear their monitoring device while on the clock. It will be worn on the collar and over any lead apron apparel. It will be left on the badge rack by the darkroom at the end of work prior to leaving the building." 2. Radiation Protection Program policy RAD12 (last approved 2/13/13) stated, "Personnel Monitoring: Each employee who uses or operates any source of radiation is required to wear a 	S001216	<p>Radiology and Procedure employees including the physician that this particular dosimetry badge belonged to, were re-educated by the Director of Quality Management on Policy RAD10 "Radiology Protection Program" RAD12 "Radiation Safety "on the proper wear and storage of their dosimetry badge as well as radiation safety. This re-education was completed by 11/15/2013. Verification of this education is maintained in the employee education files. To ensure future compliance, on 11/1/2013, the Environmental Safety rounds were updated to include checking for the proper wearing and storage of dosimetry badges which is completed by the Safety Officer or designee. Compliance will be documented on the Environmental Safety rounds and reported at the monthly QAPI meeting as well as the quarterly OIC/MEC/GB committees by the Safety Officer. This audit will continue until a compliance rate of 90% is achieved and maintained for a minimum of 3 months. The Chief Nursing Officer is ultimately responsible for the ongoing compliance of this regulation.</p>	11/15/2013			

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	<p>dosimetry badge. When off duty, employees must leave the badge on the hangar provided."</p> <p>3. At 2:45 PM on 10/16/13, the Radiology Treatment room was toured. Inside the room was a lead apron rack for employees to hang their lead apron apparel. However, one of the lead aprons was observed with a dosimetry badge hanging from the collar.</p> <p>4. At 2:50 PM on 10/16/2013, staff member #16 confirmed the observations.</p>				