STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
S 0000 Bldg. 00	The visit was for a licensure survey. Facility Number: 003767 Survey Date: 7-6/8-15 QA: cjl 08/04/15	S 0000		
S 0394 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 2 contracted services. Findings: 1. On 7-8-15 at 0900 hours, a list of contracted services was received from administrator A1. The list of services	S 0394	1.) The Chief Executive Officer has updated and verified the contracted services database to include the services provided by each vendor. 2.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive	09/15/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	failed to indicate a service provider for peripherally-inserted central line catheters (PICC lines) or the medical transcription service. 2. On 7-8-15 at 1105 hours, the administrator A1 and the director of quality management A3 confirmed the list of contracted services failed to indicate the PICC line provider or medical transcription service for the facility.		Committee and Governing Board.	
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to assure that 3 services (laboratory services, surgery services, and respiratory therapy services) were evaluated and reviewed through the Quality Assessment and Performance Improvement (QAPI) program.	S 0406	1.) The Annual Contract Services Review has been updated and verified. 2.) The Director of Quality Management notified the contract providers and has received	09/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	Findings: 1. The 2014 Quality Assessment and Performance Improvement (QAPI) Plan (approved 2-14) indicated the following: "Processes with a direct or indirect impact on patient care delivery, outcomes and cost, as well as the quality of the hospital operations shall be reviewed under the program...(all) ...services, either hospital-owned or contracted, shall participate ..." 2. 2014 Annual Contract Services Review documentation failed to indicate monitoring data was collected and reported on 4 of 4 quarters for the offsite laboratory services. No documentation indicated monitoring data was collected or reported for the surgery services provided by the host facility at the main hospital or off-site location. Review of the respiratory therapy service provided at the main hospital and off-site location failed to indicate monitors for a process or aspect of the service provided by the department or staff. 3. During an interview on 7-08-15 at 1300 hours, the administrator A1 confirmed that the QAPI program lacked documentation of ongoing monitoring for the off-site laboratory service, surgery		quality data. Monthly quality indicators, areas of concern and educational opportunities completed by contract providers to be received monthly and/or quarterly for review by the Director of Quality Manager. 3.) Director of Quality Management and/or Quality Coordinator will complete in house audits for each service provided by contract providers to ensure quality of services. 4.) Director of Quality Management to present all quality data received to the Infection Control Committee. 5.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	services or respiratory therapy services and confirmed that no additional documentation was available.			
S 0556 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on document review and staff interview, the facility failed to ensure an active, effective, and written hospital-wide infection control program for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases. Findings: 1. Infection Control (IC) Plan was reviewed on 7/8/15 at approximately 2:15 PM, and indicated on pg: A. 1, "Infection control is integrated into the hospital's Quality Assessment and Improvement efforts." B. 2, under Scope of Plan section, bulleted points, "This plan through policies, procedures, outcome assessment	S 0556	1.) Director of Quality Management has received the annual antibiogram. 2.) Director of Quality Management will contact the microbiology department from the contracted service to obtain a copy of the antibiogram annually. 3.) Director of Quality Management to present the current antibiogram for evaluation by the Infectious Disease physician in the Infection Control Committee on or before 8/27/15. 4.) Director of Quality Management will receive the antibiogram and present the results to the Infection Control	09/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	and reporting will cover the following areas...Current antibiogram; Prevention strategies: approaches to appropriate isolation identification and implementation, asepsis, cleaning, disinfection and sterilation; Specific high risk conditions and implementation of evidence-based guidelines: Pneumonia, VAP (ventilator acquired pneumonia), device related infections, Influenza prevention; An approach to MDRO's (multi drug-resistant organisms); A plan for surveillance; A plan to identify and manage outbreaks." 2. The 2014 Annual Evaluation of the IC Program and IC Plan for 2015 was reviewed on 7/8/15 at approximately 12:05 PM, and indicated under Risk Area section, on pg: A. 5, "Active surveillance culture program results: no actions taken and evaluation is blank for Strategy, Who is responsible, How monitored, and Target/goal." B. 6, "Antibiogram: under Actions Section it states 'Isn't available at this time' and Strategy: DQM (Director of Quality Management) will call the microbiology department to obtain a copy of the antibiogram; Who is responsible: DQM/ICP (Infection Control Preventionist); How Monitored: The DQM and/or ICP will discuss the results		Committee annually for evaluation. 5.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	of the antibiogram with the Infectious Disease Physician." 3. Staff 11 (Quality Coordinator [QC]) and 12 (DQM) were interviewed on 7/8/12 at approximately 2:01 PM and confirmed they are responsible for management of the infection surveillance, prevention and control program as the Infection Control Officers. The Infection Control Plan for 2015 lacks an active surveillance culture program and evaluation of antibiogram. The QC and DQM stated they have been unable to get culture reports and antibiograms from the host microbiology lab.			
S 0566 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (e)(1)(2) (e) The chief executive officer, medical staff, and executive nurse shall do the following: (1) Be responsible for the implementation of successful corrective action plans in affected			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	problem areas. (2) Provide for appropriate infection control input into plans for renovation and new construction to ensure awareness of federal, state, and local rules that affect infection control practices as well as plan for appropriate protection of patients and employees during construction or renovation.			
	Based upon document review and interview, the chief executive officer, medical staff and executive nurse failed to ensure an effective corrective action was implemented in response to an increase in Clostridium difficile (C-diff) infections identified in 2014 through the Infection Control (IC) program. Findings: 1. The June, 2014 Infection Control and Hospital Epidemiology article titled Strategies to Prevent Clostridium difficile Infections in Acute Care Hospitals: 2014 Update indicated the following: "Approaches to minimize C. difficile transmission from the environment ... Create a unit-specific checklist based on cleaning protocols and perform observations to monitor cleaning practice ...many hospitals use checklists, environmental rounds, fluorescent markers, and/or ATP bioluminescence to assess the cleaning and disinfection	S 0566	1.) Director of Quality Management and/or the Quality Coordinator will complete 10 documented observations a month with housekeeping services for cleaning related to isolation rooms. 2.) Director of Quality Management and/or the Quality Coordinator will complete 30 documented observations a month related to proper PPE usage/hand washing by all floor staff. 3.) Director of Quality Management to present all data to the Infection Control Committee for review and recommendations. 4.) Director of Quality Manager has received copies of all completed education related to cleaning requirements per policy with all housekeeping staff completed by the contracted provider.	09/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	process ..." 2. The 2014 Annual Evaluation of the IC Program and IC Plan for 2015 (approved 2-15) indicated the main facility had identified a significant increase in the number of patients infected with C-diff during the 3rd quarter and the YTD (year to date) occurrences in 2014 at the main facility. Recommendations to increase emphasis on PPE (personal protective equipment) and hand hygiene were noted and no documentation indicated a recommendation to assess the environmental services (EVS) personnel for compliance with facility policy or for adequacy of the cleaning and disinfecting processes in use at the facility. 3. The 2014 Annual Evaluation of the IC Program and IC Plan for 2015 (approved 2-15) failed to indicate that quarterly EVS monitoring of 10 patient rooms for adequacy of cleaning was performed and reported by the director of quality management, quality coordinator, or infection preventionist in accordance with the IC Plan for 4 of 4 quarters in 2014 and no IC committee recommendations were documented in the annual evaluation and plan. 4. During an interview on 7-06-15 at 1530 hours, the infection preventionist		5.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	A2 and the current director of quality management A3 confirmed that no hospital staff was currently monitoring the EVS staff for compliance with facility policy or for the adequacy of cleaning and disinfecting processes used for standard and infected patient room cleaning.			
S 0570 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed. Based on document review and staff interview, the facility failed to ensure all members of the Infection Control	S 0570	1.) Director of Quality Management created a new sign in sheet to distinguish attendees	09/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	Committe were present at infection control meetings that meet at least quarterly. Findings: 1. Infection Control (IC) Plan was reviewed on 7/8/15 at approximately 2:15 PM, and indicated on pg: A. 1, "Infection control is integrated into the hospital's Quality Assessment and Improvement efforts." B. 4, under Addendum to Introduction section, bulleted points, "Committee Profile: Infection Control Committee: Chairman: Medical Advisor IC; Standing Members: DQM (Director of Quality Management), Infection Control Officer, DCS (Director of Clinical Services, DOP (Director of Pharmacy), Microbiology lab representative, Community representative, Safety Officer, Plant engineering, and CEO (Chief Executive Officer)." 2. Job descriptions for the Quality Coordinator (QC) and the DQM were reviewed on 7/8/15 at approximately 11:55 AM, and indicated both are responsible for implementing the IC Plan and assure reporting as required. 3. QAPI (Quality Assessment and Performance Improvement) meeting		clearly. 2.) Director of Quality Management and/or the Quality Coordinator will send reminders to all required attendees on up-coming dates. Phone calls will follow for attendees that have not responded. Packets will be available in advance for the members not able to attend in person so they may call into the conference line to actively participate. If required attendees are not able to be present the Infection Control Committee will be rescheduled to ensure proper attendance. 3.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	minutes were reviewed on 7/8/15 at approximately 11:45 AM, and indicated: A. May (Dated June 2, 2015) meeting for the East Chicago and Porter facilities lacked representation by a representative from administration. B. June 2015 meeting for the East Chicago facility lacked representation by a representative from nursing and the Portage facility lacked representation by a representative from administration. 4. Staff 11 (Quality Coordinator) and 12 (Director of Quality Management) were interviewed on 7/8/12 at approximately 2:01 PM and confirmed they are responsible for management of the infection surveillance, prevention and control program as the Infection Control Officers. The Infection Control Committee is part of the QAPI Committee and reports at the QAPI meeting. The above-mentioned QAPI/IC meeting minutes lacked a representative from administration and/or nursing as required by the Infection Control plan.			
S 0592 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i) (f) The hospital shall establish an infection control committee to monitor and guide the infection control			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	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: (i) Sanitation. Based on document review and interview, the infection control (IC) program failed to review and approve the cleaning and disinfecting policies and procedures for two contracted environmental services (EVS) providers or otherwise ensure that housekeeping services were provided according to the IC policy/procedures of the facility by the EVS provider for the main campus (EVS-a) and off-site (EVS-b) locations. Findings: 1. On 7-06-15 at 1635 hours, the administrator A1 was requested to provide documentation indicating either the hospital IC committee had reviewed and adopted the cleaning and disinfecting policy/procedures and disinfectants provided for use by EVS-a and EVS-b or indicating the providers EVS-a and off-site EVS-b were oriented to the hospital's policies/procedures for	S 0592	1.) Director of Quality Management has reviewed the Select Medical policy regarding Housekeeping Services with the contracted provider. 2.) Director of Quality Management has reviewed the Select Medical policy regarding approved cleaning products with the contracted provider. 3.) Director of Quality Management and/or the Quality Coordinator will complete 10 documented observations a month with housekeeping services. 4.) Director of Quality to present all observations information to the Infection Control Committee for review and recommendations. 5.) The Infection Control Committee has reviewed all policies and procedures. Changes to policy and procedures will be reviewed at each Infection Control Committee meeting. 6.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee,	10/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	cleaning and disinfecting standard and infected patient rooms with approved hospital-grade disinfectants and no documentation was provided prior to exit. 2. During an interview on 7-06-15 at 1520 hours, the host facility director of engineering A9 and the EVS-a manager A12 confirmed that the EVS-a personnel were following the host hospital cleaning and disinfecting policy/procedures for occupied and terminal patient room cleaning at the main campus location. 3. During an interview on 7-07-15 at 1045 hours, the EVS-b manager A15 confirmed the EVS-b personnel were following the EVS management service's procedures for cleaning and disinfecting patient rooms and provided documentation indicating an annual review of the procedures was performed by the host hospital's IC representative. 4. During an interview on 7-08-15 at 1110 hours, the administrator A1 confirmed that no documentation of the hospital's IC committee review and approval was available for the cleaning and disinfecting procedures in use by the two contracted services personnel.		Organizational Improvement Committee, Medical Executive Committee and Governing Board.	
S 0606 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	(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: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and staff interview, the facility failed to implement its policy and procedure related to determining the communicable disease history of health-care personnel (HCP) for 12 of 18 (#5-8 and 11-17) personnel records reviewed. Findings: 1. Policy titled, "Employee Screening: New Hire and Ongoing" was reviewed on 7/7/15 at approximately 11:45 AM, and indicated on pg. 2, under Immunization Records section, point a., "Proof of measles and mumps and rubella immunity is only required if required by the state."	S 0606	1.) The Quality Coordinator completed an employee health file audit to identify missing required documentation. 2.) The Human Resource Coordinator will require all new employees starting on 7/9/16 or later to provide upon hire a medical history report to include varicella, measles, mumps and rubella vaccinations, or evidence of immunity. If proof cannot be provided; new hires will be required to undergo titer testing for immunity status prior to their start date and a booster to be administered dependent on results. 3.) The Human Resource Coordinator will require all current employees hired prior to 7/9/2015	12/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	2. Policy titled, "Infection Control Manual" was reviewed on 7/7/15 at approximately 11:55 AM, and indicated on pg. 2, under section III., Other Vaccines, points A. and B., "There may be specific local/state requirements that include other vaccines...Measles, mumps and rubella titers may be required by local/state health authorities." 3. CDC (Centers for Disease Control and Prevention) Recommended Adult Immunization Schedule and Guideline for Infection Control in Hospital Personnel was reviewed on 7/7/15 at approximately 11:45 A12:00 PM, and indicated on pg. 2, point: A. "4. Varicella vaccination: All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose...Evidence of immunity to varicella in adults includes any of the following: documentation of 2 doses of varicella vaccine at least 4 weeks apart; U.S. (United States) born before 1980 except health-care personnel (HCP) and pregnant women; history of varicella based on diagnosis or verification of varicella disease by a health-care provider; history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health-care		to adhere to the following schedule: Administration/non-clinical submitted by 9/30/2015; Pharmacy, Rehab, Respiratory submitted by 10/31/2015; Nursing submitted by 11/30/2015. Employees that are not in compliance by the stated submitted date will be removed from the schedule. All documentation will be placed in the employee's health file. 4.) The Human Resources Coordinator, Director of Quality Management and/orthe Quality Coordinator will monitor on an ongoing monthly basis and data will be reported on a quarterly basis. 5.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	provider; or laboratory evidence of immunity or laboratory confirmation of disease." B. "7.: a. Measles, mumps, rubella (MMR) vaccination: All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella. b. HCP born before 1957: For unvaccinated HCP born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella." 4. Review of personnel records on 7/7/15 at approximately 11:05 AM and 7/8/15 at approximately 10:45 AM, indicated staff number: A. 5-7 and 11, 12, 14, 15, 17, and 18: a. lacked documentation of 1 or more doses of MMR vaccine; or medical contraindication to the vaccine; or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	laboratory evidence of immunity to each of the three diseases. B. 8 and 11-18: b. lacked proof of immunity to varicella by documentation of 2 doses of varicella vaccine at least 4 weeks apart; history of varicella based on diagnosis or verification of varicella disease by a health-care provider; history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health-care provider; or laboratory evidence of immunity or laboratory confirmation of disease 5. Staff 11 (Quality Coordinator) was interviewed on 7/8/12 at approximately 2:20 PM and confirmed the above-mentioned personnel records were lacking documentation of communicable disease history and/or immunity to MMR and/or varicella as required by facility policy and procedure and CDC guidelines. The facility follows the CDC Guideline for Infection Control in Hospital Personnel.			
S 1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	152024		07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
Bldg. 00	410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on document review, observation, and staff interview, the facility failed to implement written policies and procedures for the appropriate storage of drugs according to policy and procedure for 1 of 1 (Inpatient Care Unit) area toured. Findings: 1. Policy No.: D14-P titled, "Security of Medication Storage Areas", revised/reapproved 2014 was reviewed on 7/8/15 at approximately 1:40 PM, and indicated under Procedure section, "All medication storage areas located throughout the hospital shall be locked or otherwise secured." 2. While on tour of the Inpatient Care Unit at the East Chicago facility, accompanied by staff 10 (Chief Nursing Officer), two Work Stations on Wheels (WOWs) were observed in the main hallway outside of patient rooms to have drawers unlocked. These drawers	S 1014	1.) The Chief Nursing Officer completed education with RNs that use the work station on wheels (WOWs) regarding policy requirements for locking drawers and reporting inoperable equipment. 2.) Materials Manager has completed an audit ensuring all WOWs have been checked for appropriate functionality. Any identified repairs needed have been completed. 3.) Chief Nursing Officer and/or Director of Quality Management will conduct an audit of 10 WOWs weekly for 3 months to ensure compliance. If compliance is demonstrated in the 3 month period the audit will then be completed with the Environment of Care rounds monthly. 4.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement	11/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312	

(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
	contained open and/or closed medications and/or needles. 3. Staff 10 was interviewed on 7/8/12 at approximately 1:30 PM and confirmed the above-mentioned WOWs contained open and/or closed medications and/or needles in unsecured drawers. Facility policy and procedure is not being followed related to drug storage and security.		Committee, Medical Executive Committee and Governing Board.	
S 1118 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on documentation review, observation and interview, the facility failed to maintain all equipment in good working order and guard against transmission of disease for one ice machine. Findings:	S 1118	1.) Director of Quality Management reviewed the last inspection completed on August 24, 2015. Going forward the maintenance and cleaning/sanitizing will be scheduled at a minimum of twice a year. 2.) Director of Engineering for the contracted service will complete	09/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	1. The manufacturer's user manual (issued 11-2008) for a Scotsman Icemaker/Dispenser models MDT5N25 & MDT5N40 indicated the following: "An ice machine is a food manufacturing plant; it takes a raw material, water, and turns it into a food product, ice...the purity of the water is very important in obtaining pure ice...in some areas, the water supply to the ice will contain a high concentration of minerals, and that will result in...(parts)...becoming coated with these minerals...maintenance and cleaning/sanitizing should be scheduled at a minimum of twice a year...the dispense area; spouts, sink, grille and splash panel will need periodic cleaning and maintenance...the ice chute may be pulled down to remove it from the ice dispenser...wash and sanitize it...the splash panel requires special attention to clean it...wash the splash panel and wipe with sanitizer..." 2. During an observation on 7-08-15 at 1320 hours, the following condition was observed in the main hospital nutrition room: a Scotsman tabletop ice machine with a 9mm x 9mm area of dark brown-colored surface residue (suspected mold) on the underside splash panel to the left of the ice dispensing outlet, a horizontal 3mm x 30mm area of black-colored surface residue (suspected		additional education with staff regarding maintenance and cleaning/sanitizing equipment scheduled for September 2015. 3.) Safety Officer and/or Director of Quality will add an additional audit to be completed monthly during Environment of Care rounds. Any issues with the equipment will be immediately reported to the Director of Engineering of the contracted service. 4.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	mold) on the clear plastic ice dispensing outlet of the ice machine, and a 2mm wide band of brown-colored scale residue encircling the open end of the stainless steel water outlet. 3. During an interview on 7-08-15 at 1320 hours, the administrator A1 confirmed the presence of the brown and black-colored residues on the ice machine surfaces and confirmed that the equipment had not been maintained.			
S 1186 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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
	authorities. Based on document review and interview, the hospital failed to follow its policy/procedure and conduct quarterly fire drills on all shifts in 2014 and 2015 at the main campus for 1 of 4 quarters (4th quarter 2014). Findings: 1. The policy/procedure Fire Safety Management Plan (approved 2-15) indicated the following: "There will be conducted on each shift in each quarter a fire drill - 100% compliance." 2. Facility documentation indicated the hospital staff participated in one fire drill on 12-27-14 at 0615 hours during the 4th quarter 2014. The administrator A1, the director of quality management A3 and the quality coordinator A4 were requested to provide documentation of staff participation in additional fire drills conducted by the host facility during the 4th quarter 2014 and no documentation was provided prior to exit. 3. During an interview on 7-08-15 at 1410 hours, the administrator A1 and chief nursing officer A2 confirmed that no additional documentation of 2014 fire drill activity was available.	S 1186	1.) During each environment of care rounds the Safety Officer will review the fire drills conducted monthly to ensure documentation has been received and reviewed. Fire drills to be conducted at least quarterly on all shifts with appropriate documentation to be maintained. 2.) Director of Quality Management will report the data to Quality Assessment and Performance Improvement, Infection Control Committee, Organizational Improvement Committee, Medical Executive Committee and Governing Board.	09/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(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