

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2015
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NAME OF PROVIDER OR SUPPLIER ST VINCENT ANDERSON REGIONAL HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2015 JACKSON ST ANDERSON, IN 46016
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005078 Survey Date: 12-28/30-2015 QA: cjl 02/08/16	S 0000	Plan of Correction completed and entered Provider signature page uploaded	
S 0102 Bldg. 00	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on document review, observation and interview, the facility failed to comply with all state, federal and local laws, by not having a Putative Father sign posted in a conspicuous location in the hospital. Findings: 1. IC (Indiana Code) 31-19-5-14 indicates public notice of purpose and operation of the (putative father) registry. A. Sec. 14 (a) Each, indicates	S 0102	On January 4, 2016 the Birthing Center manager posted the "Notice to Putative Father's" notification in the waiting area of the BirthingCenter. The notification is posted inEnglish and Spanish. The notificationincludes where registration forms can be obtained, where to register,requirements for registration, when to register, and consequences of notregistering. (See attached document) On January 8, 2016 the Director of Quality, Risk Managementand Regulatory Readiness confirmed that the "Notice to Putative Father's"	01/04/2016

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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S 0318	<p>posting shall be in (3) hospital; Shall post in a conspicuous place a notice that informs the public about the purpose of the registry. B. The notice under the subsection (a) must include information regarding the following:</p> <p>(1) Where to obtain a registration form. (2) Where to register. (3) The circumstances under which a putative father is required to register. (4) Under section 12 of this chapter a putative father is required to entitle the putative father to notice of an adoption. (5) The consequences of not submitting a timely registration.</p> <p>2. During a tour of the facility Obstetrics Unit, on 12/29/2015 at 1030 hours, accompanied by staff member #A1, it was noted that a putative father notice could not be located.</p> <p>3. Staff member #A1 concurred that the facility did not have a putative father notice posted anyplace in the hospital.</p> <p>410 IAC 15-1.4-1</p>		<p>was posted in the Waiting Area of the Birthing Center. Deficiency was corrected on January 4, 2016.</p>		

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Bldg. 00	<p>GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) for all health care workers, in accordance with current standards of practice for 1 of 2 medical staff credential files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of 2 medical staff credential files indicated the file of MD#2, hospitalist, did not have any documentation of CPR competency. Interview of employee #A1, on 12-30-2015 at 4:35 pm, indicated there was no documentation and none was provided prior to exit. 	S 0318	<p>On March 17, 2016 the "Cardiopulmonary Resuscitation (Code Blue)" policy was revised by the Chief Medical Officer and approved by the Chief Nursing Officer. Policy revisions include: Purpose: To ensure that a physician with demonstrated CPR competency will be present any time a patient requires CPR Policy Statement: Medical staff members providing direct patient care may from time to time encounter a patient in cardiac arrest or near cardiac arrest The nature of medicine is such that certain specialties such as emergency medicine, anesthesiology, critical care physicians and hospitalist more commonly encounter cardiac arrest or near cardiac arrest</p>	03/21/2016	

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			<p>situations Training: Physicians,nurse practitioners and physician assistants providing direct patient care in the Emergency Department are required to be Board Certified in EmergencyMedicine or have a current ACLS certification. The American College of Emergency Physicians supports that Emergency Physicians maintaining an active practice in their field of specialty along with Board Certification is more than adequate demonstration of ongoing competency to deliver CPR. Those Emergency Physicians who are not board certified demonstrate their competency by ACLScertification. Emergency Department physicians are required to respond to all Code Blues. Anesthesiologist and CRNA's providing direct patient care in the Operating Room are required to maintain Board Certification in Anesthesiology or have a current ACLScertification. Anesthesiologist and CRNA's demonstrate their competency in CPR by sustaining an active practice intheir field of specialty. Critical Care physicians and Hospitalists providing direct patient care in the hospital are required to be Board Certified in an appropriate related specialty or have a current CPR certification. These physicians demonstrate their competency in CPR by sustain an active practice intheir</p>	

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S 0406 Bldg. 00	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(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:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 3 services directly-provided by the hospital and 2 services provided by a contractor, as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p>	S 0406	<p>field of specialty. Many other physicians, nurse practitioners and physician assistants maintain competency in CPR but this not a requirement. Ongoing peerreview is an integral part of the quality of care review process and every CodeBlue is evaluated for quality of care. Revised "CPR-Code Blue" policy is attached Referenced section of the Medical Staff By-laws is attached</p> <p>On February 1, 2016 all of the following quality monitors were developed and data is being collected for each monitor. Data will be reported quarterly and reviewed semi-annually by the Patient Safety and Quality Committee. Oncology will measure compliance with breast cancer patients receiving radiation therapy. Goal 90%</p>	02/01/2016	

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the directly-provided services of oncology (for the 4th quarter), laundry and neonatal nursery. 2. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted services of biohazard waste hauler and nursing. 3. Interview of employee #A1, Director Quality, Risk, and Regulatory Readiness, on 12-28-2015 at 2:25 pm, confirmed there was no monitors and standards for Oncology and no other documentation was provided by exit. 4. Interview of employee #A1, on 12-30-2015 at 4:50 pm, confirmed there was no monitors and standards for laundry, neonatal nursery, biohazard waste hauler, and contracted nursing. No other documentation was provided by exit. 		<p>Laundry will monitor percent of stained linen pieces that were treated, stain removed and able to be returned to service. Goal 90% Neonatal nursery will monitor skin-to-skin contact implemented and documented. Goal: 80% Biohazard waste hauler (Stericycle) percent of times Stericycle makes a weekly pick-up and sends documentation of the destruction of the hazardous wastes. Goal 100% Contracted Nursing responsiveness of nursing staff to patient's call button. Goal is 65.05% All measures will be reported quarterly to Patient Safety and Quality Committee. This deficiency was corrected by February 1, 2016.</p>		

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S 0714 Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(2)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(2) A unit record system of filing should be utilized. When this is not possible, a system shall be established by the hospital to retrieve when necessary all divergently located record components. Based on observation and interview, the facility failed to document a system for retrieving all divergently located medical records in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 12-29-2015 at 10:55 am, it was observed at the Radiation Therapy and Outpatient Oncology areas at the Erskine Medical Office Building offsite, there were paper medical records stored in each area. Interview of staff in these areas indicated the records were stored there until a later date, sometimes significantly later, at which time they would be scanned into the electronic medical 	S 0714	On February 18, 2016 policy entitled "Medical Record Retrieval from the Cancer Center" was approved. This policy details the processes that were in place at the time of the Dec 28-30, 2015 survey. A policy was not in place at the time. See attached policy.	02/18/2016

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S 0804 Bldg. 00	<p>record.</p> <p>3. On the above date and time, employee #A1, Director Quality, Risk and Regulatory Readiness, was requested to provide documentation of a policy describing as system for retrieving both the electronic and paper medical records, which were divergently located.</p> <p>4. Interview of employee #A1 on 12-30-2015 at 4:15 pm indicated there was no such policy and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and interview, it could not be determined the</p>	S 0804	At the time of the survey it was unclear to the Director, Quality, Risk and Regulatory Readiness	01/04/2016

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	<p>medical staff followed its bylaws and rules and regulations to conduct current outcome oriented performance evaluations for 2 of 2 medical staff credential files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the medical staff bylaws and rules and regulations indicated they did not include how to conduct outcome oriented performance evaluations. 2. Review of 2 medical staff credential files indicated MD#1, emergency department physician and MD#2, hospitalist, had documentation of current outcome oriented performance evaluations. However, since there was no policy of medical staff bylaw and/or medical staff rule and regulation as to how to perform the evaluation, it could not be determined the evaluations were in accordance with medical staff bylaws and/or rules and regulations, 3. Interview of employee #A1, Director Quality, Risk and Regulatory Readiness, on 12-30-2015 at 4:30 pm, indicated there was no medical staff bylaw and/or rules and regulation policy on how to conduct current outcome oriented performance evaluations. No other documentation was provided prior to 		<p>that surveyor was referring to Ongoing Professional Practice Evaluation when questions were asked related to conducting outcome oriented performance evaluations. It is the policy of the Medical Staff of St. VincentAnderson Regional Hospital to conduct outcome oriented performance evaluations per the policy entitled "Provider Practice Evaluation" (See attached policy) Per the Definitions and Action Steps: Ongoing Professional Practice Evaluations (OPPE) process is defined, including that the OPPE provider quality profiles will be generated bi-annually and distributed in a timely manner to the provider and a copy will be place in the confidential provider specific file maintained by Quality Management. This policy was originated in July 2009 and last revised in June 2014. This deficiency was resolved on January 4, 2016.</p>	

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S 1020 Bldg. 00	<p>exit.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</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>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on document review, it could not be determined that the facility documented monthly pharmacy inspection reports were reviewed by the pharmacist in 1 instance.</p> <p>Findings include:</p> <p>1. Review of a document entitled MEDICATION QUALITY ASSURANCE ROUNDS REPORT, Date 9-29-15, Unit Chemo Rx [pharmacy], Pyxis I, Pyxis II, did not document the inspection report was reviewed by the pharmacist.</p>	S 1020	<p>Review of the policy (Unit Inspections) in place at the time of the survey stated the inspection was completed by the Director of Pharmacy or his/her designee. Thus, implying that this inspection was to be completed by a pharmacist. On February 5, 2016 the Manager of Pharmacy Services revised the policy entitled "Unit Inspections" to state "Inspections of all units containing medications are conducted by Pharmacy personnel to ensure that medications are appropriately labeled and stored, sufficiently stocked and within expirations limits. A list of units to be inspected is maintained in the Pharmacy. <u>Pharmacy Technicians</u> are the designee of</p>	02/22/2016			

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S 1160 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on document review, the hospital failed to regularly maintain 1 piece of patient care equipment in accordance with facility policy.</p>	S 1160	<p>the Director of Pharmacy and are responsible for completing the unit inspections. Pharmacy Technicians are assigned specific units to inspect. A standardized form is used to document each inspection. The Pharmacy Technician completing the form is responsible for signing the form verifying that the inspection was completed." All Pharmacy Technicians were educated on the change to this policy on February 5, 2015.</p> <p>February 22, 2016 this policy was updated to include: "The Pharmacy Operations Manager is responsible for reviewing and signing the administrative copy of the form each month". The Pharmacy Operations Manager is a Pharmacist.</p> <p>This deficiency was corrected on February 22, 2016.</p> <p>December 29, 2015—It was determined on the afternoon of survey that the associate (newly hired) who logged the temperature below 120 degrees had not left the thermometer in</p>	01/27/2016

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S 1164 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility Policy Title: CDE.65- Hot packs, Paraffin and Fluidtherapy, revised Nov 6., 2013, indicated complete a work order and notify Trimedics for repair. If the temperature is below 120 [degrees Fahrenheit], the unit may continue to be used, but a work order should still be completed, and Trimedics contacted for repairs. 2. Review of a document used to record daily Paraffin Unit temperature checks for December, 2015 indicated in the Temp column an entry value of 110. 3. Employee #A6, Physical Therapist, on 12-29-2015 at 10:50 am, was requested to provide documentation of a work order and notification of Trimedics relative to the above-stated document entry. In interview on that date and at that time, the employee indicated no documentation was available and none was provided by exit. <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as</p>		<p>the paraffin bath long enough to obtain an accurate reading. The newly hired associate was re-educated on the proper process of checking the temperature of the paraffin bath by her supervisor on December 29, 2015. On January 25, 2016 the Director of Rehabilitation Services updated the "Hot Packs, Paraffin and Fluidotherapy" policy to state: "Document all actions taken when temperature falls outside the listed parameters on the log sheet or any action taken due to concerns with the device. Date/time each action taken on the log sheet". Log sheet was updated to accommodate documentation of actions taken. January 27, 2016 "Hot Packs, Paraffin and Fluidotherapy" policy with above changes noted in "red" was routed via email to all department associates. Department supervisor to review "Log Sheet" monthly to monitor for compliance with documentation of daily recording of temperature and that appropriate actions taken if temperature is out of range. This deficiency was corrected on January 27, 2016.</p>		

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	<p>follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings include:</p> <p>1. On 12-28-2015 at 10:45 am, employees #A3, Director Medical Facilities and #A4, Manager Medxcel, were requested to provide documentation of PM on the facility's emergency code call system.</p> <p>2. Interview of employee #A4 on 12-30-2015 at 4:20 pm, indicated there was no documentation on the above-requested equipment and none was provided prior to exit.</p>	S 1164	<p>On January 4, 2016 the Director of Facilities Management developed a Preventive Maintenance for the Emergency Code Call System to include:</p> <ol style="list-style-type: none"> 1. Inspect amplifier for any unusual fan noise or vibration. 2. Connect the cable marked "House Music" into the input of Channel 6 on the rear of the amplifier. 3. Change the volume of Channel 6 to approximately '3' and do not change any other input volumes. 4. Turn the 24 position rotary switch to the number corresponding to the being tested and listen for music at the amplifier rack. 5. Walk the zone the amplifier controls and confirm that each speaker is working. 6. Return to amplifier room, turn down Channel 6 volume to '0' and disconnect 'House Cable' from input Channel 6. <p>The Preventive Maintenance for the Emergency Code Call will be completed on March 28, 2016 and then annually by the Manager</p>	03/28/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			of FacilitiesManagement. This deficiency will be corrected on March 28,2016.		