

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150001	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2014
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NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 W JEFFERSON ST FRANKLIN, IN 46131
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005001</p> <p>Survey Date: 2-3/5-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 03/05/14</p>	S000000		
S000270	<p>4/10/14 revised due to IDR</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p>			

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

TITLE

(X6) DATE

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

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	<p>Based on document review and interview, the governing board failed to review reports of quality activities for 9 directly-provided services and 7 contracted services in calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the directly-provided services of bariatrics, central sterile, dietary, electroencephalography, hyperbaric chamber, laundry, reportable events, response to patient emergencies, and sleep lab. 2. Review of governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the contracted services of biomedical engineering, biohazardous waste hauler, blood bank provider, PET Scan, renal dialysis, tissue transplant and outpatient wound care, 3. In interview, on 2-4-14 at 3:00 pm, employee #A4 confirmed the governing board did not review for calendar year 2013 the quality activities of 9 directly-provided services and 7 contracted services. 	S000270	S 0270 Attachments: 1. "0270-001 PI Annual Summary 2013.pdf" POC: The governing board will receive, in the existing Performance Improvement Annual Summary, numeric results from performance improvement indicators for both directly provided services and for contracted services. As evidence of the proposed process please see the attachment titled "0270-001 PI Annual Summary 2013.pdf". Pages, marked "Attachment A" and "Attachment B", of the attachment contain specific content to address deficiency S 0270. Content includes 4thquarterperformance indicator and quality monitor results as required for reporting to the governing board. The changes to the PI Annual Summary were created by and will be an ongoing responsibility of Quality Manager William Mink, RN. Responsibility for presenting the PI Annual Summary to the hospital governing board will lie with Chief Nursing Officer Anita Keller, RN, MSN, ONC, CPHQ, CENP. The plan of correction for deficiency S 270 was started on March 5th, 2014 and will be completed on March 24th, 2014 when the content of attachment "0270-001 PI Annual Summary 2013.pdf" will be presented to the hospital governing board at their regularly scheduled meeting. Findings	03/24/2014			

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S000362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p>		<p>specific to "reportable events" are addressed in our response to S 420. Findings specific to "response to patient emergencies" are addressed in our response to S 408.</p>				

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	<p>Based on document review and interview, the hospital failed to comply with their contract by not notifying their organ procurement organization of 8 of 110 deaths for the year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO), dated February 28, 2007, indicated [the] hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), in the Hospital. 2. Review of a report provided by IOPO, indicated that for the period January 1, 2013 through December 31, 2013, there were 102 hospital deaths. 3. In interview, on 2-4-14 at 2:00 pm, employee #A9 indicated according to hospital data, the hospital had 110 deaths for the same above time period. No further documentation was provided prior to exit. 	S000362	<p>S 0362</p> <p>Attachments: 1. "0362-001 IOPO Report 2013.pdf" 2. "0362-002 IOPO Report Email.pdf" 3. "0362-003 IOPO Emails.pdf" 4. "0362-004 IOPO SBAR.pdf"</p> <p>POC: We believe the findings for S 0362 are the result of miscommunication between the hospital and Indiana Organ Procurement Organization (IOPO). Further investigation showed that all deaths were in fact reported to IOPO as evidenced by attached IOPO report titled and labeled "0362-001 IOPO Report 2013.pdf" and attached email "0362-002 IOPO Report Email.pdf" received 3/12/14. While investigating this matter we did find a process problem for which we have taken action. We were not receiving email notifications because IOPO's email notices were sent to staff no longer employed by the hospital. Although we had not responded to their notices, IOPO did not follow up any further. Discovering that miscommunication is documented in an attachment of emails labeled "0362-003 IOPO Emails.pdf". A summary of the problem and resolution is in attachment "0362-004 IOPO SBAR.pdf" written by Michelle Bisesi, RNC-OB, MSN, NEA-BC who will have continuing responsibility to ensure the new process is carried out. This</p>	03/12/2014	

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S000406	<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.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 4 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p>	S000406	<p>situation has been corrected by establishing new hospital contacts for IOPO. The new contacts, Inez Dailey and Jody Miller, have been communicated to IOPO as evidenced by attachment "0362-003IOPO Emails.pdf". These new contacts will be responsible for faxing hospital death reports to IOPO and receiving notices from IOPO. The reporting system used for staff to call IOPO when appropriate will not be changed because we have found that system to be adequate with all deaths in 2013 reported.</p> <p>S 0406 Attachments: 1. "0406-001 Environmental Services PI Plan2014.pdf" 2. "0406-002 Environmental Services PI Report2014.pdf" 3. "0406-003 Laboratory PI Plan 2014.pdf"</p>	03/24/2014	

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	<p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services of biohazardous waste hauler, blood bank, renal dialysis and tissue transplant.</p> <p>2. In interview, on 2-4-14 at 3:00 pm, employee #A4 confirmed the above and no further documentation was provided prior to exit.</p>		<p>4. "0406-004 Laboratory PI Report 2014.pdf" 5. "0406-005 Med Surg PI Plan 2014.pdf" 6. "0406-006 Med Surg PI Report 2014.pdf" 7. "0406-007 Surgical Services PI Plan 2014.pdf" 8. "0406-008 Surgical Services PI Report 2014.pdf" 9. "0406-009 Contracted Services 2014.pdf" POC: Performance Improvement (PI) plans have been updated to include quality monitors for the contracted services noted in S 0406. Evidence of the PI Plan update is provided as attachments of individual departmental PI Plans and PI Reports for 2014. The responsible persons are listed and related attachments are labeled as follows. The relevant section of the attachment is marked with pdf drawing markup.</p> <p>1. Stericycle Medical Waste Systems – biohazardous waste hauler a. Responsible person: Mike Pryor, Environmental Services Manager b. "0406-001 Environmental Services PI Plan2014.pdf" (see page 4) c. "0406-002 Environmental Services PI Report2014.pdf" (page 1) 2. South Bend Medical Foundation – supplier of blood for the hospital blood bank a. Responsible person: Bev Hall, Blood Bank Section Head b. "0406-003 Laboratory PI Plan 2014.pdf" (see page7) c. "0406-004 Laboratory PI Report 2014.pdf" (seepage 1) 3. Fresenius – renal dialysis</p>		

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			<p>service a. Responsible person: Shelia Pittman, RN, MSN, Med/Surg Manager</p> <p>b. "0406-005 Med Surg PI Plan 2014.pdf" (see page 3)</p> <p>c. "0406-006 Med Surg PI Report 2014.pdf" (see page 3)</p> <p>4. Multiple vendors – tissue transplant product suppliers a. Responsible person: Beth Bylsma, RN, MSN, Surgical Services Director</p> <p>b. "0406-007 Surgical Services PI Plan 2014.pdf"(see page 3)</p> <p>c. "0406-008 Surgical Services PI Report 2014.pdf"(see page 1)</p> <p>The changes to the PI Plans and Reports were created by and will be an ongoing responsibility of the individual Department Managers as listed above. The Department Managers are also responsible for collecting data, ensuring ongoing reporting, and creating action plans for unmet goals. Responsibility for presenting the PI Plan changes to the hospital governing board will lie with Chief Nursing Officer Anita Keller. Our Contracted Services List, presented to the governing board, was updated to include missing services as evidenced by document "0406-009 Contracted Services 2014.pdf". The plan of correction for deficiency S 0406 was started on March 5th, 2014 and will be completed on March 24th, 2014 when the PI Plan additions will be presented to the hospital governing board.</p>		

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S000420	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part</p>						

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	<p>of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability</p>			

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	<p>associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability</p>			

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	<p>associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or</p>			

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	<p>provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the hospital failed to include reportable events as part of its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include reportable events.</p> <p>2. In interview, on 2-4-14 at 3 pm, employee #A4 confirmed there were no reports of reportable events as part of the facility's QAPI and no documentation was provided prior to exit.</p>	S000420	<p>S 0420</p> <p>Attachments: 1. "0420-001 ISDH Event Report.pdf" 2. "0420-002 BOT minutes 2014-02.pdf" 3. "0420-003 PIC minutes 2014-03.pdf" POC: An Adverse Reportable Event (ARE) was reported to the IN State Dep't of Health (ISDH) as required on January 8th, 2014 as evidenced by attachment "420-001 ISDH Event Report.pdf". This ARE had not been reported to the governing board at the time of the ISDH licensing survey. The governing board has received report of the ARE as demonstrated on page 3 of attachment "420-002 BOT minutes 2014-02.pdf", the governing board's minutes for February 2014. There were no AREs in 2013. It is the practice of the hospital to report AREs to the governing board, however the timing of the ISDH licensing survey was such that this ARE had not yet been reported. To ensure that AREs are reported as necessary this has been added as a permanent agenda item for</p>	03/12/2014	

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review and interview, the hospital failed to follow manufacturer instructions for testing of Cidex test strips upon opening a new bottle of test strips in 1 instance, failed to follow manufacturer's recommendations for testing of Cidex OPA solution before each use in 1 instance and failed to follow its policy to change the Cidex solution every 10 days.</p> <p>Findings:</p> <p>1. Review of manufacturer instructions</p>	S000554	<p>the PI Council meetings of which the Vice-chairperson of the governing board is a member. The new agenda item is discussed in March 12th, 2014 PI Council meeting minutes attached as "420-003 PIC minutes 2014-03.pdf". Relevant section is marked on pages 4 & 5. This additional reporting is intended to ensure that ARE communication is redundant to avoid missed reporting. The person responsible for ensuring AREs are reported to the governing board and to the PI Council is Quality Manager William Mink, RN.</p> <p>S 0554</p> <p>Attachments: 1. "0554-002 Cidex Tools.pdf" 2. "0554-003 Cidex Staff Information Email.pdf" POC: As indicated by attached email "0554-003 Cidex Staff Information Email.pdf", log sheets were obtained from the manufacturer of Cidex OPA and a process was identified which will ensure compliance with use and testing of the Cidex solution and test strips. The new log sheets are attached as "0554-002 Cidex</p>	

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	<p>entitled H. Quality Control Procedures, indicated it is recommended that the testing of positive and integrative controls be performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips.</p> <p>2. Review of a document entitled ULTRASOUND DEPARTMENT OPA CIDEX SOLUTION FOR TRANSACTIONAL PROBES, ULTRASOUND SCAN ROOM 1, dated 11-12-13 through 1-23-14 [the Cidex Test Document], indicated no documentation of testing positive and negative controls for any newly opened bottle of test strips</p> <p>3. In interview, on 2-4-14 at 10:00 am, a hospital staff member of the ultrasound department confirmed there was no testing of the strips on newly opened bottles. No further documentation was provided prior to exit.</p> <p>4. Review of a document entitled CIDEX OPA SOLUTION HANDLING PROTOCOL indicated [to] Test strength of Cidex OPA every time you use it with the test strip.</p> <p>5. In interview, on 2-4-14 at 10:00 am, a hospital staff member of the ultrasound department, when questioned on the frequency of testing the solution, indicated it was not tested if it was used 2 or more times per day.</p> <p>6. Review of the Cidex Test Document indicated a statement at the bottom indicating the SOLUTION IS CHANGED EVERY TEN DAYS ROUTINELY.</p> <p>7. Review of the above stated document indicated the solution was changed every 14 days, as indicated by the notation NEW.</p>		Tools.pdf". The new process and log sheets address all findings for S 0554 and have already been implemented. The implementation of this process has been communicated to pertinent staff by Medical Imaging Manager Randy Collins on 3/12/14 as evidenced by attachment "0554-003 Cidex Staff Information Email.pdf". Medical Imaging Manager Randy Collins is responsible for ensuring compliance with the process.		

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S000784	<p>8. In interview, on 2-4-14 at 10:00 am, a hospital staff member of the ultrasound department confirmed the solution was changed every 14 days. No further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(5)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(5)Description of treatment given or prescribed, clinical observations, including the results of treatment, and the reports of procedures and test results, if applicable.</p> <p>Based on document review and interview, the facility failed to ensure that Emergency Department (ED) medical records (MR) documented and contained clinical observations from consults for 1 of 2 ED transfer MRs reviewed (Patient #11).</p> <p>Findings include:</p> <p>1. Review of patient #11's MR indicated the patient presented to the ED on 01-06-14. The ED physician requested a tele psych consult. Review of patient #11's MR lacked documentation of the results of the tele psych consult.</p> <p>2. On 02-05-14 at 1420 hours, staff #53 confirmed the tele psych consults do not provide documentation of the consult to be included in the patient's MR.</p>	S000784	<p>S 0784</p> <p>Attachments: 1. "0784-001 Telepsychiatric Services Policy.pdf" 2. "0784-002 Telepsych Email to Physicians.pdf" 3. "0784-003 Telepsych PI Tool.pdf" 4. "0784-004 Emergency Dept PI Report 2014.pdf" 5. "0784-005 Patient Chart A.pdf" 6. "0784-005 Patient Chart B.pdf" POC: Telepsychiatry services have been added to the Emergency Department's (ED) performance improvement (PI) process to ensure assessments are received for the patient's medical record in a timely manner and that ED physicians document telepsychiatry discussion in the medical record. This PI process addition is evidenced on page 2</p>	
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S000912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an		of attachment "0784-004 Emergency Dep't PI Report 2014.pdf", a quarterly report of PI activity, and attachment "0784-003Telepsych PI Tool.pdf", a tool to assist in data collection. ED physicians received education on 3/12/14 (attachment "0784-002Telepsych Email to Physicians.pdf") on the existing hospital telepsychiatry policy which outlines expectations for documentation, discussion, and receipt of assessments. The hospital policy is attached as "0784-001 Telepsychiatric Services Policy.pdf" with relevant sections marked on page 6. As examples of change in practice we submit two recent patient medical record portions as attachments "0784-005 Patient Chart A.pdf" and "0784-005 Patient Chart B.pdf". These examples show that ED physician documentation of discussion with a telepsychiatric therapist has occurred and was documented and the full telepsychiatric assessment has been delivered for inclusion in the hospital medical record. All patient identifiers have been removed and only relevant portions of the record are included. Relevant sections have been annotated.		

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	<p>organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the facility failed to ensure that nursing staff followed established policy / procedures for obstetrical (OB) patients' recovery in 2 of 2 OB medical records (MR) reviewed.</p> <p>Findings include:</p> <p>1. Review of policy / procedure Maternity Center Recovery for Vaginal or Cesarean</p>	S000912	S 0912 Attachments: 1. "0912-001 Maternity PI Report 2014.pdf" 2. "0912-002 Maternity Meeting Minutes 2014-02-20.pdf" 3. "0912-003 Maternity Chart Audit Tool 2014.pdf" POC: Aldrete scoring and documentation compliance has been added as a performance improvement indicator for the	02/20/2014			

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S000952	<p>Section Delivery indicated the following: "The Aldrete scoring guide will be used to assess the patient's condition following childbirth with epidural anesthesia. The Aldrete scoring guide will be utilized at the beginning of the recovery period and again before discharge from the recovery period." This policy / procedure was last reviewed / revised on 03-12-12.</p> <p>2. Review of patient #4's MR indicated the patient had epidural anesthesia for delivery of a baby on 02-02-14. Patient #4's MR lacked documentation of the Aldrete scoring guide being documented at discharge from the recovery phase.</p> <p>3. Review of patient #12's MR indicated the patient had epidural anesthesia for delivery of a baby on 12-14-13. Patient #12's MR lacked documentation of the Aldrete scoring guide being documented at discharge from the recovery phase.</p> <p>4. On 02-04-14 at 1225 hours, staff #48 confirmed the Aldrete scoring guide was not documented prior to discharge from the recovery phase for patient #4.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have</p>		<p>Maternity department as shown on page 1 of attachment "0912-001 Maternity PI Report 2014.pdf". Chart audits for this PI study have already started. The tool used for auditing Aldrete scoring compliance and other PI indicators is shown in attachment "0912-003 Maternity Chart Audit Tool 2014.pdf". Chart auditing will take place at a rate of 100% of charts audited for 6 months, then 50% of charts audited for 6 months, then 25% of charts audited for 6 months. Nursing Services Director Michelle Bisesi, RNC-OB, MSN, NEA-BC will be responsible for ensuring chart audits are completed and that staff are compliant with hospital policy for Aldrete scoring. Maternity staff education for Aldrete scoring expectations was completed on 2/20/2014 in a Maternity Center staff meeting which staff are required to attend. Attachment "0912-002 Maternity Meeting Minutes 2014-02-20.pdf" shows on pages 1 & 2 that such discussion took place.</p>		

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	<p>special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on policy/procedure review, transfusion record review and staff interview, the facility failed to follow approved medical staff policies and procedures for the administration of 3 of 7 transfusions reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> On 2/4/14 between 12:30 p.m. and 1:30 p.m. review of a policy/procedure titled: "BLOOD PRODUCT ADMINISTRATION CODE; NR.6011.B.06 effective date: 3/23/12" indicated the following: <ol style="list-style-type: none"> "10. Obtain the patient's TPR" (Temperature, Pulse, Respirations) "within 30 minutes prior to beginning transfusion and document within Process Transfusions." On 2/4/14 between 1:30 p.m. and 2:30 p.m. review of transfusion records indicated transfusions numbers T#2, T#3, and T#4 had no pre TPRs recorded per policy/procedure. On 2/4/14 Staff persons #2 and number #10 acknowledged the above lack of pre or prior TPRs. 	S000952	<p>S 0952</p> <p>Attachments: 1. "0952-001 Blood Product Transfusion Policy.pdf" 2. "0952-002 Transfusion Memo.pdf" 3. "0952-003 Transfusion Audit Tool.pdf" POC: The hospital policy for transfusing blood products has been amended to require staff to obtain and document vital signs prior to obtaining a blood product from the blood bank and within 30 minutes prior to the start of a transfusion. This policy change is evidenced in attachment "0952-001 Blood Product Transfusion Policy.pdf". Page3, points 6 & 7 are especially pertinent. All clinical staff who transfuse blood have been informed of this policy change by attached memo "0952-002Transfusion Memo.pdf". This memo includes education on changes to the blood transfusion policy, instructions specific to timing of vital signs and terminology for documentation, as well as a documentation screenshot for ease of staff identification. This memo was sent by Chief Nursing Officer Anita Keller to all clinical care staff through department managers on 3/12/2014. In order to ensure compliance with the policy changes, medical record auditing will begin on April 1st 2014. The tool to be used for</p>	03/12/2014	

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and document review, the hospital created a condition which resulted in a hazard to employees in 1 instance.</p> <p>Findings:</p> <p>1. On 2-3-14 at 2:00 pm in the presence of employee #A1, it was observed in the</p>	S001118	<p>chart audits is attached as "0952-003 Transfusion Audit Tool.pdf". The audits will be conducted by Blood Bank Section Head Bev Hall on the following schedule. · 100% of all blood transfusions audited April2014 – October 2014 · 50% of all blood transfusions audited November2014 – April 2015 · 25% of all blood transfusions audited May 2015 –October 2015The tool that will be used for performing these audits is attached as "0952-003 Transfusion Audit Tool.pdf".</p> <p>S 1118</p> <p>Attachments: 1. "1118-001 Eyewash Station Response Communication.pdf" 2. "1118-002 Eyewash Station Checklist.pdf" 3. "1118-003 Work Order for Eyewash Station.pdf" 4. "1118-004 Preventive Maintenance Sheet.pdf" POC: The immediate correction for</p>	02/20/2014	

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S001150	<p>housekeeping equipment storage room, there was an eyewash device. The water level in the device was observed to be approximately 6 " below a line which indicated 15 minute flush fill line.</p> <p>2. On that same date and time, review of a manufacturer's label above the device indicated the solution should be refilled every 4 months or when below the 15 minute flush fill line.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and</p>		<p>citation S1118 was to fill the eyewash station to the proper level. As evidenced by attachment "1118-001Eyewash Station Response Communication.pdf" and attachment "1118-003 Work Order for Eyewash Station.pdf" this deficiency was fully corrected on 2/20/2014 with the following additional remedies. · A log was placed at the eyewash station which will be used to visually demonstrate weekly checks of the eyewash station including filling station to proper level. This documentation is evidenced by attachment "1118-002 Eyewash Station Checklist.pdf". · Mike Pryor, Environmental Services Manager, is responsible to ensure the eyewash stations will be checked weekly. Attachment "1118-001Eyewash Station Response Communication.pdf" shows agreement to this process.In addition to weekly checks by Housekeeping staff, Maintenance staff will do quarterly checks to ensure compliance. This process is evidenced by attachment "1118-004 Preventive Maintenance Sheet.pdf",specifically the second to last entry "HOUSEKEEPING EQUIP. ROOM 1STFL".</p>				

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	<p>facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the facility failed to install a backflow prevention device as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 2/3/14 at 1:35 pm, in the presence of employee #A1, it was observed in the rehabilitation unit the shower had a flexible hose connected to a water spigot without a backflow preventer.</p>	S001150	<p>S1150</p> <p>Attachments: 1. "1150-001 Shower Backflow Communication.pdf" 2. "1150-002 Shower Backflow Work Order.pdf" 3. "1150-003 Replacement Showerhead Photo.pdf" POC: Citation S1150 has been corrected by installing a showerhead without a hose that cannot reach a standing water level. In addition, staff have been informed that a backflow prevention valve must be used with a hose type system and that device has been ordered to assist with ease of patient care. This correction is evidenced by attachment "1150-001 Shower Back Flow Communication.pdf" from Chris Snyder, Facility Director. Attachment "1150-002 Shower Backflow Work Order.pdf" demonstrates the work done to correct the deficiency on 3/11/14. Attachment "1150-003 Replacement Showerhead Photo.pdf" shows the new showerhead of a type which does not require a backflow prevention</p>	03/11/2014

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S001164	<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 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.</p> <p>Based on observation, document review and interview, the hospital failed to provide evidence of preventative maintenance (PM) for 3 pieces of equipment.</p> <p>Findings:</p> <p>1. In interview, on 2-3-14 at 1:30 pm, employee #A1 was requested to provide documentation of PM on a dishwasher and toaster in the occupational therapy area of the rehabilitation unit, used as part of patient treatment.</p>	S001164	<p>valve. This is a temporary showerhead which will be replaced by a hose type showerhead with a backflow prevention valve. If documentation regarding the replacement showerhead is required please inform us and we will provide that documentation as soon as possible after the new device is installed.</p> <p>S1164</p> <p>Attachments: 1. "1164-001 Work Order for Scale.pdf" 2. "1164-002 Dishwasher Inspection Photo.pdf" 3. "1164-003 Toaster Inspection Photo.pdf" POC: All items referenced in S1164 have been inspected by the Clinical Engineering department of Community Health Network as our contracted supplier of biomedical engineering services. Inspections are evidenced by attachment "1164-001 Work Order for Scale.pdf" showing</p>	03/12/2014	

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	<p>2. In interview, on 2-4-14 at 10:35 am, employee #A1 was requested to provide evidence of PM on an electronic unit scale located in the mammography department.</p> <p>3. No documentation of PM was provided for the above pieces of equipment prior to exit.</p>		<p>work order completed for the mammography scale, attachment "1164-002 Dishwasher Inspection Photo.pdf" for the rehabilitation unit dishwasher, and attachment "1164-003 Toaster Inspection Photo.pdf" for the rehabilitation unit toaster. The photos show the actual new inspection stickers. All inspections were completed by 3/12/14.</p>		