

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151307	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/06/2014
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT WILLIAMSPORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 412 N MONROE ST WILLIAMSPORT, IN 47993
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 11/5/2014 through 11/6/2014</p> <p>Facility Number: 005092</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 01/09/15</p>	S000000		
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 documentation review, observation and staff interview, the</p>	S000554	On November 10, 2014 EMS Manager, Supply Chain Team Lead, CEO, Safety Officer and Quality Coordinator met in the	01/23/2015

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>facility failed to maintain an environment that minimized risk to patients for the Emergency Medical Services (EMS) Department.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. St. Vincent Williamsport Safety Management Plan (last approved 10/2013) indicated the hospital will ensure safe working conditions and practices throughout the facility. St. Vincent Williamsport Hospital is committed to provide an environment that minimizes risks to patients, visitors and associates.</li> <li>2. At 2:15 PM on 11/5/2014, the EMS Department's Garage was inspected. The garage had two free-standing white wooden cabinets and 1 free-standing brown metal cabinet. The cabinets were observed packed with assorted medical supplies: loose packages of infant suction catheters, cervical collars, bed pans, accu-check supplies, disposable gowns,</li> </ol>		<p>EMS garage to set up a plan of action to remove, destroy, and eliminate medical supplies stored in the EMS garage. 1. The EMS Manager, an appointed EMS associate and the Supply Chain Team lead will sort through the supplies. Outdated and damaged supplies will be destroyed or if in acceptable condition used for teaching. This was completed on December 5, 2014. 2. EMS will no longer maintain a stock pile of medical supplies in the EMS garage. They will restock the ambulances from the hospital warehouse or the Emergency Department supplies. This process for stocking supplies began November 24, 2014. 3. EMS staff were educated on the new process by the EMS manager on November 18, 2014. 4. Supplies found to be specific to EMS use only will be stored in totes with tight fitting lids in an area protected from water spray. Totes purchased and supplies placed in totes away from water spray was completed on December 8, 2014. These supplies will be monitored weekly by assigned EMS staff for outdate and integrity. EMS Manager will conduct random checks of the supplies to ensure integrity and report to the Health and Safety Team (Name for our IFC committee members include: Safety Officer, Risk Management, Administration, Medical Staff rep. IFC officer, Quality/Surgery</p>				

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	<p>assorted catheters, lab tubes, suction tubing; and assorted boxes of medical supplies. The loose packaging and the assorted boxes were observed with water damage on the cardboard boxes and brownish stains were observed on several plastic wrappings of the single packages in the cabinets. Plastic packaging of yellow gowns was observed ripped, exposing the gowns to outside environmental conditions.</p> <p>3. At 3:05 PM on 11/5/2014, staff member #5 (EMS Department Manager) indicated the packages and boxes of supplies had water damage because water excess from the washing of the ambulances seeps through the cabinets. Diesel fuel excess is the brown stain that was observed on several of the individual packages of medical supplies.</p>		<p>Manager, Med/Surg Manager, Lab. Manager, Rad. Manager, Interim ER Manager and Supply Chain Team Lead). 5. White wooden cabinets will be removed from the EMS garage by Hospital Maintenance Department. EMS Manager will be responsible for contacting Maintenance Department to remove cabinets. Completed on January 23, 2015. The EMS Manager will be responsible for the removal of the supplies in the EMS garage, ensuring the supplies that are specific to EMS are maintained in a dry environment and are not outdated or damaged. The EMS Manager is also responsible for ensuring no other supplies are stocked in the EMS garage.</p>				

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on documentation review, observation and staff interview, the facility failed to ensure chemical disinfectants were used accordingly to the manufacturer's recommendations for the ultrasound probes and the mammography scanner.</p> <p>Findings included:</p> <p>1. St. Vincent Williamsport Ultrasound Probe Cleaning policy #1082262 (last approved 6/2013) indicated the rinsing procedure of Matricide Plus 30 high-level</p>	S000596	<p>November 17, 2014 Radiology Manager and Quality Manager consulted the manufacturer's recommendation on cleaning our ultrasound probes. The policy containing the information on cleaning ultrasound probes was revised to read: 1. After every exam, remove the transducer cover. Disconnect transducers from the ultrasound system. 2. Ensure the gel and any remaining contaminants are completely wiped off the transducer. 3. Wearing gloves and protective eye cover wipe surface with two towels until completely wet. Allow surface to remain wet for two (2) minutes. The active ingredients in the wipes require a two (2) minutes wet time for disinfection. Wipe with a clean damp cloth, allow to air dry and discard used</p>	01/21/2015

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	<p>disinfectant was to rinse the residue off of the ultrasound probes three separate times in copious volumes of water by immersing the probe at least 1 minute each time.</p> <p>2. At 11:55 AM on 11/5/2014, St. Vincent Williamsport Hospital's Radiology Department was toured. The hospital was using Matricide plus 30, high level disinfectant for semi-critical devices. Matricide plus 30 manufacturer sheet indicated for the manual rinsing procedure: thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times; each time should be done for a minimum of 1 minute; and always use fresh water each time this step is done.</p> <p>3. At 12:00 PM on 11/5/2014, staff member #17 (Ultrasound Technician) indicated the procedure on rinsing the ultrasound probes off of the Matricide high-level disinfectant. The staff</p>		<p>towel. 4. A log will be maintained to record the date, time, and person who disinfected the probe. The specifications for Super Sani-Cloth Germicidal Disposable wipes and the manufacturer's recommendations on cleaning the Mammography scanner were reviewed by the Radiology Manager and Mammography Technician on November 18, 2014. The Technician has revised her process for cleaning and will allow the surfaces to remain wet for 2 minutes and air dry. Having the technician review the recommendations herself allowed her to better understand the importance of wet time and disinfection. The Radiology Manager will conduct random checks and observe the technician disinfecting the scanner. The observations will be reported to the Health and Safety Team Bi monthly. November 24, 2014 The Radiology Manager and Quality Manager conducted an unannounced observation to observe the disinfection of the ultrasound probe and Mammography scanner. The technician for each item followed the recommended practice. January 21, 2015 the Quality Manager (Radiology Manager was ill and not present) presented the manufacturer's recommendation for cleaning the ultrasound probe and Mammography scanner and the</p>	

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	<p>member indicated after the probes are soaked in the Matricide disinfectant for at least 30 minutes, the probe is held under running water from the sink's faucet in the restroom for a minute or two. The staff member confirmed the ultrasound probes are not rinsed off of Matricide disinfectant as stated in the hospital policy and manufacturer's recommendations.</p> <p>4. At 12:15 PM on 11/5/2014, the Mammography scanner room was toured. The room had Super Sani-cloth containers stored on the counter in the room. Staff member #18 (Mammography Technician) demonstrated the process of disinfecting the scanner. The staff member used a Sani-cloth to wipe off the scanner followed immediately by a paper towel to wipe any surface of the scanner that was still wet by the Sani-cloth. The beginning of the process of using the Sani-cloth to disinfect the scanner followed by the paper towel was 45 seconds.</p>		<p>updated policy on ultrasound probe cleaning to the Health and Safety Team (IFC committee). The Team approved the updates. It was also report the technicians were observed following the new recommendations. The Radiology Manager will be responsible for overseeing the technicians follow policy disinfecting the ultrasound probes and Mammography scanner and maintaining the log.</p>		

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	<p>5. Super Sani-Cloth Germicidal Disposable Wipes manufacture specification sheet indicated the wipes have a 2-minute contact time; which requires the surface of the scanner to remain wet for 2 minutes. The manufacturer recommends the surface to air dry and not to wipe the excess off with a dry towel.</p> <p>6. At 1:25 PM on 11/6/2014, staff member #2 (Quality Assurance Director) indicated the hospital staff were re-educated on the contact times of the different disinfectant used within the hospital. The staff member indicated the demonstration observed in the Mammography Scanner Room did not comply with the manufacturer's recommendations on proper contact time and allowing the sanitizer to air dry.</p>			
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S000598	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on documentation review, observation and staff interview, the facility failed to ensure the Radiology Department's Ultrasound Room was complying with FDA requirements on not refilling Ultrasound Gel containers.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However,</p>	S000598	<p>November 10, 2014 Radiology Manager, Quality Manager, Supply Chain Team Lead and Ultrasound Technician met. The FDA recommendations were reviewed. A decision to order enough empty containers to use up the bulk Ultrasound Gel was agreed upon. On November 14, 2014 twenty four (24) bottles were received, filled, and labeled with the bulk ultrasound gel by the Ultrasound Technician. All bulk ultrasound gel containers were removed from the department and destroyed. The Radiology Manager and Ultrasound Technician were assigned the task of educating the radiology associates regarding the dangers</p>	01/07/2015

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	<p>past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</p> <p>2. At 12:00 PM on 11/5/2014, the Radiology Department's Ultrasound room was inspected. Located in the room was a counter with several 16-ounce ultrasound gel containers and a partial bulk plastic container of Aquasonic Ultrasound Gel. On the counter top was an Aquasonic Gel thermal sonic warming unit with plastic bottles warming in the unit.</p> <p>3. At 12:05 PM on 11/5/2014, staff member #17 (Ultrasound Technician) indicated he/she refills the ultrasound gel plastic bottles. The staff member indicated a box containing 1 empty plastic bottle</p>		<p>of refilling the Ultrasound gel containers. The Radiology Manager stated this was completed on November 20, 2014. Supply Chain Team Lead has stocked the warehouse with Aquasonic Ultrasound Gel in individual bottles. She has assured the Health and Safety Team bulk Aquasonic Ultrasound Gel will no longer be purchased and stocked. On January 7, 2015 the Safety Officer following safety rounds reported no bulk ultrasound gel found, only individual bottles. The Radiology Manager is responsible for ensuring radiology no longer re-fills ultrasound gel containers from bulk containers. No bulk ultrasound gel will be ordered. The Radiology Manager will report to the Health and Safety Team monthly that no ultrasound gel containers are being refilled.</p>	

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S000608	<p>and a bulk plastic container of Aquasonic Ultrasound Gel. The empty plastic container would be refilled several times with the bulk container of ultrasound gel until it is empty.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy review, observation and interview, the facility failed to ensure the surgical staff followed their dress code policy and nationally recognized guidelines regarding surgical masks.</p>	S000608	November 7, 2014 the Surgery Manager conducted a Safety Huddle for the surgery team. The team was re-educated on the dress code policy and guidelines regarding surgical masks; "High filtration masks shall be worn at all times in the surgical suites and	11/24/2014

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	<p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility's policy "Attire in the Operating Room", last reviewed 10/2014, indicated, "High filtration masks shall be worn at all times in the surgical suites and other areas where open sterile supplies or scrubbed personnel are located. Masks shall cover the nose and mouth and shall be discarded whenever removed."</li> <li>During the tour of the surgical department at 12:05 PM on 11/05/14, accompanied by staff member #2, the Quality/Surgery Manager, the following observations were made: <ol style="list-style-type: none"> <li>A female surgical staff member was sitting at the desk in the recovery room with a surgical mask hanging around her neck on the front of the scrub top.</li> <li>A female staff member and a male staff member were at the bedside of a patient in the recovery room with surgical masks hanging around their necks on the front of their scrub tops.</li> <li>A female staff member was going back and forth between the recovery room and operating room with a surgical mask hanging around her neck on the front of the scrub top.</li> </ol> </li> <li>At 2:30 PM on 11/06/14, staff member #2 confirmed the facility</li> </ol>		<p>other areas where open sterile supplies or scrubbed personnel are located. Masks shall cover the nose and mouth and shall be discarded whenever removed." Team members were reminded when they lowered their mask, they are to remove and discard it. They are not to wear it around their neck. All team members acknowledged and stated they understood. Everyone agreed to remind each other. November 10 – December 5, 2014 a bulletin board display outside the surgery hallway titled "Attire in the OR" featured removing and discarding surgical masks. The Surgery Manager at least two times per week but not limited to have observed the surgery team providing patient care. No incidents of masks being worn around the neck have been observed since November 24, 2014. The Surgery Manager will continue to observe for incidents of masks being worn around the neck and correct the occurrence if found. The Surgery Manager is responsible for ensuring the surgery team does not allow masks to worn around neck. The Surgery Manager will report findings of violations and how it was corrected to the Health and Safety Team monthly.</p>				

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S000762	<p>followed AORN guidelines which also indicated surgical masks should be removed at the completion of each case and not worn around the neck.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(13) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.</p> <p>Based on review of the Medical Staff Rules and Regulations, medical record review, and interview, the facility failed to ensure all medical records for patients hospitalized for greater than 23 hours contained a timely and authenticated discharge summary for 10 of 24 (#N1, N2, N3, N4, N6, N14, N16, N21, N22, and N23) records reviewed of patients who were discharged over 30 days ago.</p> <p>Findings included:</p>	S000762	December 8, 2014 the Health Information Manager reported to Administration, Medical Staff and Quality all medical records were up to date and contained a timely and authenticated discharge summary. January 5, 2015 a new electronic process has been put into place to track the completion of the discharge summary in the medical record in Sovera by Health Information Manager. A paper copy of the medical record is placed in the physician's dictation area box with a	01/05/2015

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	<p>1. Review of the facility's "Medical Staff Rules and Regulations", last reviewed January 2013, indicated, "9.10. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. ...9.13. A discharge summary shall be written and/or dictated on the medical record of all patients hospitalized more than twenty-three (23) hours. A short stay summary may be dictated for the patients with stays less than twenty-three hours. ...9.22. A practitioner's charts will be considered delinquent at thirty (30) days."</p> <p>2. The medical record for patient #N1 indicated a discharge date of 06/09/14, but a discharge summary not dictated until 08/03/14 and authenticated on 08/05/14.</p> <p>3. The medical record for patient #N2 indicated a discharge date of 08/11/14, but a discharge summary not dictated until 10/19/14, and not authenticated by the practitioner.</p> <p>4. The medical record for patient #N3 indicated an admission date of 07/08/14 and a discharge date of 07/10/14, but the record lacked a discharge or short stay summary.</p>		<p>notification what needs to be completed and the date it needs to be completed by. Weekly notification of what is delinquent or nearly delinquent is sent per e-mail to CEO, CFO, Director of Nurses, Med/Surg Manager, Utilization Review Coordinator, and North and South Clinic Manager. These individuals are asked to remind and facilitate the physicians. The Health Information Manager or an appoint Health Information associate will take the greatest responsibility track and notify and ensure the physicians are completing the discharge summary. An update on the effectiveness of the electronic process will be reported on in the February Medical Staff meeting (Second Tuesday of the month at 0600) and each meeting to follow. The Health Information Manager is responsible for ensuring discharge summaries are completed using the Medical Staff Rules and Regulations as guidelines.</p>	

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NAME OF PROVIDER OR SUPPLIER  ST VINCENT WILLIAMSPORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 412 N MONROE ST WILLIAMSPORT, IN 47993
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	<p>5. The medical record for patient #N4 indicated a discharge date of 07/22/14, but a discharge summary not dictated until 10/02/14 and authenticated on 10/08/14.</p> <p>6. The medical record for patient #N6 indicated a discharge date of 09/15/14, but a discharge summary not dictated until 11/02/14 and authenticated on 11/05/14.</p> <p>7. The medical record for patient #N14 indicated a discharge date of 07/18/14 and a discharge summary dictated 08/12/14, but not authenticated by the practitioner.</p> <p>8. The medical record for patient #N16 indicated a discharge date of 08/05/14, but a discharge summary not dictated until 10/22/14, and not authenticated by the practitioner.</p> <p>9. The medical record for patient #N21 indicated a discharge date of 08/06/14, but a discharge summary not dictated until 09/21/14 and authenticated on 10/01/14.</p> <p>10. The medical record for patient #N22 indicated a discharge date of 07/08/14, but a discharge summary not dictated until 08/17/14, and not authenticated by</p>			

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S000787	<p>the practitioner.</p> <p>11. The medical record for patient #N23 indicated a discharge date of 08/11/14, but a discharge summary not dictated until 11/01/14, and not authenticated by the practitioner.</p> <p>12. At 2:30 PM on 11/06/14, staff member #2, the Quality/Surgery Manager, and staff member #19, the Health Information Manager who navigated the Electronic Medical Records, confirmed the medical record findings and the lack of timely and authenticated discharge summaries.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(8)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(8) Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal. Based on medical record review and interview, the practitioner failed to document the condition on discharge for 5 of 19 patients (#N1, N4, N5, N8, and N18) and failed to document the correct disposition on 1 of 19 patients (#N22) in the areas</p>	S000787	January 12, 2015 Quality Manager met with the CEO (Interim Emergency Department Manager) to review the Indiana State Department of Health Statement of Deficiencies	01/23/2015

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	<p>provided on the Emergency Physician Records.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The medical record for patient #N1 indicated an ED (Emergency Department) visit on 06/04/14 with a subsequent hospital admission, but the Emergency Physician Record lacked documentation of the "Condition on Disposition".</li> <li>2. The medical record for patient #N4 indicated an ED visit on 07/18/14 with a subsequent hospital admission, but the Emergency Physician Record lacked documentation of the "Condition on Disposition".</li> <li>3. The medical record for patient #N5 indicated an ED visit on 04/25/14 with a subsequent hospital admission, but the Emergency Physician Record lacked documentation of the "Condition on Disposition".</li> <li>4. The medical record for patient #N8 indicated an ED visit on 07/20/14 with a subsequent hospital admission, but the Emergency Physician Record lacked documentation of the "Condition on Disposition".</li> <li>5. The medical record for patient #N18 indicated an ED visit on 05/25/14 with a subsequent hospital admission, but the Emergency Physician Record lacked documentation of the "Condition on Disposition".</li> <li>6. The medical record for patient #N22 indicated an ED visit on 07/05/14 with a subsequent hospital admission, but the Emergency Physician Record indicated documentation that the patient was transferred to another facility.</li> <li>7. At 2:30 PM on 11/06/14, staff member #2, the</li> </ol>		<p>regarding Emergency service records shall document and contain, but not be limited to, the following: Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal. The Interim ED Manager and Quality Manager agreed the ED Chief Medical Officer will be contacted to notify and remind ED physicians to document the "Condition on Disposition". This was completed on January 15, 2015. A safety net was put into place by the Interim ED Manager on January 15, 2015; the ED staff is to check the record, when tearing it down to send to medical record, to ensure the physician has completed the "Condition on Disposition". If the physician has not completed the staff is to give the record to the ED physician to complete. A review of 50 records by the Quality Manager January 19 – 23, 2015 revealed 100% compliance. The Quality Manager will continue to review charts while abstracting OP Quality Measures and Communication Measures and report finding at the IEC monthly meeting (ER physicians, Administration, Quality and Department Managers meet monthly to review ER processes, patient flow, and quality findings). The ER Manager is responsible for ensuring the ER physicians are completing the Condition on</p>	

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

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	Quality/Surgery Manager, and staff member #19, the Health Information Manager who navigated the Electronic Medical Records, confirmed the medical record findings and the lack of correct documentation by the ED practitioners.		Disposition.		