

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
C000000	<p>The visit was for investigation of a Federal critical access hospital complaint.</p> <p>Complaint Number: IN 00127897</p> <p>Substantiated: Deficiencies cited related and unrelated to the allegations.</p> <p>Date: 12-30-13 and 12-31-13</p> <p>Facility Number: 005072</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/07/14</p>	C000000		
C000271	<p>485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedures to ensure a triage assessment was documented for all patients presenting to the Emergency Department (ED) for emergency and</p>	C000271	<p>The policy/procedure will be revised to specify all obstetrical patients presenting to the Emergency Department will be triaged prior to diagnostic testing. This triage assessment will include physician input and be documented in the medical</p>	03/01/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>obstetrical care for 1 of 8 (patient 27) MR reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Admission, Transfer, Discharge: Emergent Medical Screening Exam (approved 12-12) indicated the following: "...triage status of the patient will be determined to be emergent, urgent, or non-urgent..."</li> <li>2. The policy/procedure Admission, Transfer, Discharge: Emergent Medical Screening Exam (approved 12-12) indicated the following: "...triage status of the patient will be determined to be emergent, urgent, or non-urgent..."</li> <li>3. The MR for patient 27 (PT 27) lacked triage documentation on arrival to the facility (4-15-13 at 1440 hours); however, ED physician MD10 ordered outpatient fetal monitoring [Non Stress Test] and a pelvic exam to be performed on the Obstetrics (OB) unit. PT 27 was examined on the OB unit by a specially trained RN in accordance with the Obstetrics unit scope of care. The testing and exam was completed and results were reported to MD10 and orders were received for PT 27 to be sent to the ED for further evaluation by MD10. The ED record indicated that a</li> </ol>		<p>record. Education will be provided of the Emergency Department staff. To prevent reoccurrence the Emergency Services Director will monitor staff compliance. Completion Date: March 1, 2014 Responsible Party: Vice President of Patient Services</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>fetal ultrasound was performed and PT 27 received pregnancy counseling from MD10 prior to discharge at 1930 hours.</p> <p>4. During an interview on 12-31-13 at 1000 hours, staff A2 confirmed that the MR for PT 27 lacked documentation of triage assessment at the time of initial presentation to the ED.</p> <p>5. During an interview on 12-31-13 at 1250 hours, staff A2 confirmed that the facility failed to follow its policy/procedure ensuring that a triage condition was documented before out-patient testing was performed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
C000280	<p>485.635(a)(4) PATIENT CARE POLICIES These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. Based on document review and interview, the facility failed to review its patient care policies/procedures at least annually by a group that included at least one Doctor of Medicine (MD) or Osteopathy (DO).  Findings:</p> <p>1. The nursing service policy/procedure titled Review and Evaluation of Policy / Procedures (reviewed 12-12) indicated the following: " Policy/Procedure manuals will be reviewed every three years by the Policy / Procedure Committee. Cover sheet will be dated and signed by Vice President of Patient Services as reviewed. " The policy/procedure failed to require all patient care policy/procedures to be reviewed annually and failed to indicate committee membership including an MD or DO in addition to a department manager, director or administrative representative.</p> <p>2. Documentation dated 12-31-09 and 12-31-12 indicated a signature by a vice</p>	C000280	<p>Patient care policies will be reviewed on an annual basis. The review committee will consist of an appropriate number of clinicians, to include a physician. The review policy will be amended to reflect the above noted changes. Completion Date: Due to the complexity of this change completion of this Plan of Correction will occur no later than 12/31/14. Responsible Party: Vice President of Patient Services.</p>	03/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/31/2013
NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978		
(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	
S000000	<p>president of patient services and failed to indicate a signature by an MD or DO to validate review of the patient care policies and procedures.</p> <p>3. On 12-31-13 at 1000 hours, staff A2 was requested to provide evidence of MD or DO participation with patient care policy/procedure development and annual review and none was provided prior to exit.</p> <p>4. During an interview on 12-31-13 at 1440 hours, staff A2 confirmed that the facility policy failed to ensure that an MD or DO participated in the development or review of the patient care policy/procedures on an annual basis and no further documentation was available.</p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00127897</p> <p>Substantiated: Deficiencies cited related and unrelated to the allegations.</p> <p>Date: 12-30-13 and 12-31-13</p>	S000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
S000406	<p>Facility Number: 005072</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/07/14</p> <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 facility failed to ensure that an incident-event was reported to the quality assessment/performance improvement program for an event requiring a police presence in the emergency Department (ED) as required per policy.</p> <p>Findings:</p>	S000406	The Emergency Department (ED) staff will complete an event report for all situations requiring police presence. Education will be provided to the ED staff. To prevent reoccurrence the Emergency Services Director will monitor staff compliance. Completion Date: March 1, 2014 Responsible Party: Vice President of Patient Services	03/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>1. The policy/procedure Event Reporting (approved 12-12) indicated the following: " An event will be considered as any happening which is not consistent with the routine operation of this facility ...This might involve a patient, visitor, resident or volunteer ...prompt reporting will help assure that all facts are accumulated, that the report is completed accurately and that corrective actions are taken to prevent recurrence ...the results ...should be reviewed by the Risk Manager and/or Quality Assurance Committees who shall recommend corrective measures, as necessary ... "</p> <p>2. On 12-30-13 at 1030 hours, staff A2 was requested to provide incident-event report documentation regarding a police presence in the ED on 4-15-13 and none was provided prior to exit.</p> <p>3. Review of 18 patient procedure and miscellaneous incident-event reports for the period 4-01-13 through 4-30-13 failed to indicate an event involving patient 27.</p> <p>4. An administrative report obtained upon request by administrator A1 and dated 4-15-13 indicated a police officer responded to a call regarding a disorderly subject in the ED at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/31/2013
NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978		
(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	
S001510	<p>approximately 1715 hours and cleared at 1725 hours.</p> <p>5. During an interview on 12-31-13, ED manager A3 confirmed that the staff (A3) was the primary care provider for the patient associated with a police presence on 4-15-13 and confirmed that the staff (A3) failed to complete an incident report regarding the event.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on document review and</p>	S001510	The policy/procedure will be	03/01/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/31/2013
NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978		
(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	
	<p>interview, the facility failed to follow its policy/procedures to ensure a triage assessment was documented for all patients presenting to the Emergency Department (ED) for emergency and obstetrical care for 1 of 8 (patient 27) MR reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Admission, Transfer, Discharge: Emergent Medical Screening Exam (approved 12-12) indicated the following: "...triage status of the patient will be determined to be emergent, urgent, or non-urgent..."</li> <li>2. The policy/procedure Admission, Transfer, Discharge: Emergent Medical Screening Exam (approved 12-12) indicated the following: "...triage status of the patient will be determined to be emergent, urgent, or non-urgent..."</li> <li>3. The MR for patient 27 (PT 27) lacked triage documentation on arrival to the facility (4-15-13 at 1440 hours); however, ED physician MD10 ordered outpatient fetal monitoring [Non Stress Test] and a pelvic exam to be performed on the Obstetrics (OB) unit. PT 27 was examined on the OB unit by a specially trained RN in accordance with the Obstetrics unit scope of care. The</li> </ol>		<p>revised to specify all obstetrical patients presenting to the Emergency Department will be triaged prior to diagnostic testing. This triage assessment will include physician input and be documented in the Medical Record. Education will be provided to the Emergency Department staff. To prevent reoccurrence the Emergency Services Director will monitor staff compliance. Completion Date: March 1, 2014 Responsible Party: Vice President of Patient Services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>testing and exam was completed and results were reported to MD10 and orders were received for PT 27 to be sent to the ED for further evaluation by MD10. The ED record indicated that a fetal ultrasound was performed and PT 27 received pregnancy counseling from MD10 prior to discharge at 1930 hours.</p> <p>4. During an interview on 12-31-13 at 1000 hours, staff A2 confirmed that the MR for PT 27 lacked documentation of triage assessment at the time of initial presentation to the ED.</p> <p>5. During an interview on 12-31-13 at 1250 hours, staff A2 confirmed that the facility failed to follow its policy/procedure ensuring that a triage condition was documented before out-patient testing was performed.</p>			