

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2015
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL AND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 800 W 9TH ST JASPER, IN 47546
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S 000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005102</p> <p>Dates: 02-16-15 to 02-18-15</p> <p>Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler, MT MS Medical Surveyor III</p> <p>QA: claughlin 03/16/15</p>	S 000		
S 308 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>			

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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the hospital failed to ensure department specific orientation for six (P1, P4, P7, P11, N4, N15) of twenty-nine personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility policy 303761, titled Orientation, updated 01/2015, indicated that a new employee shall receive both a general hospital and a departmental orientation. The employee's department will conduct Department Orientation, which consists of a systematic and specific introduction to the functioning of a specific department according to the employee's assigned position which is to include: job descriptions and a departmental orientation checklist. On 02/16/2015, of eleven non-nursing personnel files reviewed, four (P1, P4, P7, P11) lacked documentation of the employees having a department specific orientation. On 02/18/2015, of eighteen nursing 	S 308	<p>Review of Facility Policy 303761, titled Orientation, update on 01/2015. 4 out of 11 non-nursing personnel files were missing department specific orientations. 2 out of 18 nursing personnel files were missing department specific orientations. Memorial Hospital and Health Care Center has a policy/process in place for these to be completed however at times a few may have been missed. To prevent this in the future, we are looking to upload department orientation files to HealthStream and assign them with due dates for all new employees with the 60 day evaluations. This will allow us to ensure that they are completed in a timely manner and that everyone is completing these consistently throughout the organization and in accordance with our policy. These will be assigned for existing employees when they move departments – new process started 4/13/15 The person that will be responsible for this process will be the HealthStream Administrator. She will also be audited for accuracy by her management team on a periodic basis to ensure that all the items are being assigned and completed. Audits will be</p>	04/13/2015

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S 312 Bldg. 00	<p>personnel files reviewed, two nursing personnel, N4 and N15, lacked documentation of the nursing staff having had department specific orientation.</p> <p>4. On 02/18/15 at 8:45 AM, A19, Human Resources Manager, and A20, Human Resources Benefits Coordinator confirmed lack of department specific orientation.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the hospital failed to ensure a job description for one (N4) of twenty-nine personnel files reviewed.</p>	S 312	<p>monthly.</p> <p>Review of Facility Policy 303761, titled Orientation, updated on 01/2015. 1 of the nursing personnel that had been reviewed was missing a job description.</p>	04/13/2015			

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S 406 Bldg. 00	<p>1. Review of facility policy 303761, titled Orientation, updated 01/2015, indicates that a new employee shall receive both a general hospital and a departmental orientation. The employee's department will conduct Department Orientation, which consists of a systematic and specific introduction to the functioning of a specific department according to the employee's assigned position which is to include: job descriptions and a departmental orientation checklist.</p> <p>2. Review of nursing personnel file of N4 indicated lack of documentation of having a job description.</p> <p>3. On 02/18/15 at 8:45 AM, A19, Human Resources Manager, and A20, Human Resources Benefits Coordinator confirmed lack of job description for N4.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p>		Memorial Hospital and Health Care Center has an established policy/process in place to ensure that job descriptions are signed off on as needed in HealthStream however this one had been missed. To prevent future issues/misses, we are taking the job description process and assigning to one person from start to finish. We are also having this audited to ensure that all required job descriptions are assigned and completed as needed. The job description will be assigned to new hires in addition to the 60 day reviews and the department specific orientations. These will also be assigned when the employee moves departments or when there is a change in title. New process began 4/13/15. The person that will be responsible for this process will be the HealthStream Administrator. She will also be audited by her management team on a periodic basis to ensure that all the items are being assigned and completed. Audits will be monthly.		

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	<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 quality assessment and performance improvement (QAPI) program failed to include 6 services in its evaluation (audiology, bariatric services, electroencephalography (EEG), electromyography (EMG), emergency psychiatric services, and ophthalmic surgery).</p> <p>Findings:</p> <p>1. Review of QAPI committee meeting minutes dated 1/20/15, 12/5/14, 10/31/14, 9/26/14, 8/22/14, 7/25/14, 6/27/14, 5/30/14, 4/25/14, 3/28/14, & 1/24/14 lacked documentation of quality evaluation/review of the following services: audiology, bariatric services, EEG, EMG, emergency psychiatric services, and ophthalmic surgery services.</p> <p>2. On 2/18/14 A2, Director of Quality</p>	S 406	Hospital QA/PI Plan reviewed:Following Excerpt from policy will be reviewed at Leadership Group meeting on 5/12/15:Hospital departments and services will be responsible for selecting and monitoring all indicators needed to assure the services defined in their scope are being provided. Each applicable department/area will have at least one Quality Assessment / Performance Improvement Process completed annually and will focus on process, safety, patient experience, or cost containment utilizing the Hospital's improvement process methodology.Each applicable department/area will submit a report of the QA/PI projects to the Quality Services Department (annually if not reporting to Quality Council quarterly) as they are completed.Each department leader will be instructed that for every service we must have a measure with goals. Measures can be monitored at the dept.	06/30/2015			

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S 612 Bldg. 00	<p>Services, confirmed the above 6 services had not been included in QAPI evaluations.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on document review and observation, the infection control committee failed to ensure compliance with their policy and procedure (P&P) for linen management in 2 areas (dirty</p>	S 612	<p>level and must be submitted to Quality Council / BOD at least annually. To prevent future failures of services not reporting, at list will be created and monitored by the Quality Services department. This list will be on a calendar rotation by Division to be reported to Quality Council / BOD. This list/calendar will be reviewed monthly by Quality Services Data Analyst. Dept. leadership will be notified of their schedule to presnet to Quality Council / BOD.Responsible: Director Quality Services</p> <p>Name:Linen Management in 2 areas (dirty linen on the floor in laundry) Date:4/27/2015 Department:Linen Services Describe what the facility did to</p>	04/27/2015	

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	<p>laundry and sleep lab).</p> <p>Findings:</p> <p>1. Review of PolicyStat ID: 947058 titled Laundry, under Procedure B, indicated: When linens become soiled they are to be bagged and left in the soiled laundry basket in the bio-hazard room. The P&P was last reviewed/approved 07/2014.</p> <p>2. Review of PolicyStat ID: 792923 titled Infection Control in Policy Statement A, indicated Sleep Center employees follow the hospital's infection control plan and policies and procedures... The P&P was last reviewed/approved 03/2014.</p> <p>3. On 2/16/15 between 1:00pm and 4:00pm during tour of the facility, in the presence of A17, Supervisor of Plant Engineering, the following was observed: In the dirty laundry room 2 large, full laundry bags on the floor, outside of the basket.</p> <p>4. On 2/16/15 at 3:30pm during tour of the sleep lab off-site, in the presence of A2, Director of Quality, and P11, Director of cardio/pulmonary/sleep lab, the following was observed: 3 large, full laundry bags on the floor of the hall.</p>				<p>correct the deficient practice for each cited in the deficiency. Informed the departments (Sterile Processing, Health and Wellness, Pulmonology & Multi-Specialty) that bring linen to the Laundry to put the linens in one of the carts provided. Posted signs in the department not to leave linens on the floor - completed 4/27/15</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>Called and talked to the department managers - completed 4/27/15</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this should include any system changes you made.</p> <p>Posted signs in the department and instructed the Linen Team Leader to contact the Director of Facilities when linen is found on the floor- completed 4/27/15 Contact then will be done to the department that</p>		

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	5. On 2/16/15 at 3:30pm P11 indicated the bags contained dirty linen and were there awaiting pick-up by a contracted laundry service.		<p>created the deficiency immediately - deficiency & Dept notification will be documented.</p> <p>Describe how the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Monitoring should Include: Who is responsibleLinen Services Team Leader and Director of Facilities The system by which the responsible person(s) will monitorVisual Frequency of monitoring.Daily Monitoring should be on-going.Will be ongoing</p> <p>Sleep Lab POC: Staff Huddle on 2/19/15 with DME staff- reviewed Laundry stipulation of bags not resting on floor while awaiting outside vendor pickup. Text/email to all Sleep Staff 2/19/15 outlining all ISDH findings and the needed changes. Order placed for Stainless Steel supporting Rack Week of March 2. Rack arrived and is in place 4/14/15. Supervisor monitoring compliance daily to prevent future occurrences. No policy change needed; staff educated on policy adherence and necessary equipment</p>	

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S 726 Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</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>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on document review, observation, and interview, the medical record service failed to provide for a procedure for unauthorized access to medical records (MR) and failed ensure that unauthorized individuals cannot gain access to patient records in 2 off-site locations (sleep lab & urology).</p> <p>Findings:</p> <p>1. Review of PolicyStat ID: 435198</p>			S 726	<p>obtained. Responsible: Director Cardiopulmonary Services</p> <p>Disposition of Records policy reviewed:Addition: All ancillary departments and offsite clinics will maintain their own medical records and documents in a secure storage area for the state-wide retention period of seven years.Education of updated policy will be provided at May 12, 2015 Leadership Group meeting.Policy signed off and approved 4/29/15 by Director Corporate Compliance, Director Health Information Management and Vice President Finance and</p>		05/13/2015

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	<p>titled Disposition of Records indicated in the section titled Procedure: 1. They (MR in process) will be kept and maintained by the Department having overall responsibility for them. The policy was last reviewed/approved 4/2013.</p> <p>2. On 2/16/15 at 3:30pm during tour of the off-site Sleep Lab, in the presence of A2, Director of Quality, and P11, Director of cardio/pulmonary/sleep lab, the following was observed: On the floor near the charting/computer station were stacked banker box style boxes, 6 closed boxes and 2 open boxes, of medical records/patient files.</p> <p>3. On 2/16/15 at 3:30pm, P11 indicated the medical records were in the process of being purged into the electronic system. He/she further indicated that the charting/computer area was a space shared with Durable Medical Equipment (DME) personnel.</p> <p>4. On 2/17/15 at 1:45pm during tour of the Urology off-site, in the presence of P13, Manager of Urology, and A7, Vice President of Patient Services, the following was observed: 5 boxes of MR on the floor of the soiled utility room.</p> <p>5. On 2/17/15 at 4:25pm, A2 indicated</p>		<p>CFO.Responsible: Director HIMUrology POC:Urology medical records were secured on March 26, 2015 at an off-site location (urgent care basement). Urology Staff and Practice Manager were educated on March 26 for the reason of the removal of these medical records. April 27, 2015 Practice Manager, reiterated this process again in the Urology Dept. Huddle and is documented in the Huddle minutes.To ensure this does not re-occur, monitoring of record storage will be done by the Practice Manager routinely during rounds at clinic.Responsible: Director Medical Practice ManagementDME/Sleep Center:Policy Confidentiality, Security and Release of Information reviewed and contains needed information.Huddle on 2/19/15 with DME staff - reviewed criteria that charts must be secure. Discussed the SBOH finding. Week of 2/23/15, these records were secured and moved to the Archives for long term secure storage. Supervisor and Director have directed staff that purges must include security of the charts at completion with immediate transport to our locked Archive storage. Review of policy required by all staff at 5/13/15 dept. meeting. This will be documented in minutes. To ensure future occurrence, Supervisor will monitor record</p>				

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S 118 Bldg. 00	<p>the facility had no specific policy/procedure for MR storage.</p> <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 facility created a condition that may result in a hazard to patients, public, or employees in 2 locations (the laundry area gas storage room and the outside medical gas storage area).</p> <p>Findings:</p> <p>1. Review of PolicyStat ID: 711683 titled PE Nitrous Oxide System, subsection Maintenance and Inspections:</p>	S 118	<p>storage routinely through the purge process. Responsible: Director Cardiopulmonary Services</p> <p>Name:Gas cylinders not secured properly Date:4/27/2015 Department:Plant Engineering Describe what the facility did to correct the deficient practice for each cited in the deficiency. Reattached the chains that were not secured to both NO2 tanks and secured the O2 tanks with chains completed 4/28/15</p> <p>Describe how the facility</p>	04/28/2015	

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	<p>1. a. viii. Once the full tanks are in place they will immediately be chained in position. The policy/procedure (P&P) was last reviewed/approved 01/2014.</p> <p>2. Review of PolicyStat ID: 717701 titled Safe Handling of Compressed Gases indicated under Procedure: 3. Storage, 1. Cylinders should always be secured an may be stored upright or laying flat in well ventilated areas. The P&P was last reviewed/approved 01/2014.</p> <p>3. On 2/16/15 between 1:00pm and 4:00pm during tour of the facility in the presence of A2, Director of Quality, and A17, Supervisor of Plant Engineering, the following was observed: In a medical gas storage closet in the laundry area were 2 unsecured Nitrous Oxide (NO2) tanks and in the outside medical gas storage area were 2 unsecured oxygen (O2) tanks.</p>		<p>reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>Notified Respiratory, DME and Surgery, EMS, and the delivery service of the deficiency - completed 4/27/15</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this should include any system changes you made.</p> <p>Daily rounds will be done to visually check to ensure all tanks are secure, this will be included on the Plant Engineering Boiler Room rounds sheets. Respiratory, Surgery, DME and EMS have all been notified of the deficiency - completed 4/27/15</p> <p>Describe how the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Daily rounds will be done to visually check to ensure all tanks are secure.</p>		

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S 168 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the facility failed to ensure defibrillators were checked and logged in accordance with policy and procedure (P&P) and manufacturers recommendation for 1 Automated External Defibrillator (AED) at 1 off-site (Sleep Lab).</p> <p>Findings:</p> <p>1. Review of the P&P titled Zoll AED Plus Manual and Automatic Self Test</p>	S 168	<p>Monitoring should include: Who is responsiblePlant Engineer The system by which the responsible person(s) will monitorVisually monitor Frequency of monitoring.Daily rounds Monitoring should be on-going.Will be on-going</p> <p>Zoll AED Sleep Center: Text and email to all Sleep Staff outlining all of the ISDH findings and the needed changes. Policy, Emergency Equipment: AED Plus, Suction Device, Emergency Cart, reviewed and revised.All items are checked by Sleep Center Personnel every shift that the Sleep Center is open for performance of studies. Policy has completed the process and is active 4/2015. To ensure no further omissions, staff are required to complete a self learning module related to the findings, the policy change, the</p>	04/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150115	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2015
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL AND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 W 9TH ST JASPER, IN 47546		
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	<p>Checks/Use of Zoll Plus CPR-D "PADZ", PolicyStat ID: 810660 indicated in B. You will need to check the AED weekly on Wednesday to confirm that the green check is present...The P&P was last reviewed/approved 06/2014.</p> <p>2. Review of the AED manufacturer manual in #7 of the Set-up and Check-out Procedure section indicated the following: Check AED Plus unit periodically to ensure that green check symbol appears in status indicator window.</p> <p>3. On 2/16/15 at 3:45pm during tour of the sleep lab off-site in the presence of P11, Director of cardio/pulmonary/sleep lab services, an AED was located in a hall area atop a crash cart. Review of the check logs was requested of P11 at that time.</p> <p>4. On 2/16/15 at 4:00pm, P11 indicated no sleep lab AED check logs were available and no documentation was provided prior to exit.</p>		<p>institution of a redesigned log, and the responsibilities of the Sleep Staff. Review made available 3/1/15 with education to sign for attestation of completion. Completion requirement date is 4/30/15. Evaluation of the April log by Director demonstrates staff adherence to the procedural change. Sleep Center Registration Clerk has responsibility to track completion and ensure logs are available and in use. One year of data is to be maintained by the Sleep Center Registration Clerk. Responsible: Director Cardiopulmonary Services</p>		