

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2015
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NAME OF PROVIDER OR SUPPLIER SCOTT MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1451 N GARDNER ST SCOTTSBURG, IN 47170
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S 0000 Bldg. 00	This visit was for State licensure survey. Dates of survey: 05/18/15 to 05/20/15 Facility number: 004778 QA: cjl 05/27/15	S 0000		
S 0272 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (a)(7) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (7) Ensure that there is a hospital-wide, quality assessment and improvement program to evaluate the provision of patient care. Based on document review and interview, the governing board (GB) failed to ensure the quality assessment and improvement program (QAPI) was hospital-wide by not including 4 of 28 directly provided services (infusion therapy, pediatrics, pharmacy, & inpatient rehabilitation), 2 of 12 functions (transcription & utilization review), and 3 of 6 contracted services (biomedical engineering, laundry, & teleradiology).	S 0272	S272 410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (a) (7) How are you going to correct the deficiency? Quality measures have been developed for the infusion therapy, pediatrics, pharmacy, inpatient rehab, transcription, utilization review, biomedical engineering, laundry & teleradiology. Data will be collected each month to track and evaluate these services. This data will be first documented	06/15/2015

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>Findings:</p> <p>1. Review of GB meeting minutes dated 4/16/15, 3/19/15, 2/19/15, 1/15/15, 12/18/14, 11/20/14, 10/23/14, 9/27/14, 8/21/14, 7/1/14, 6/19/14, 5/15/14, 3/20/14, & 2/20/14 lacked evidence of QAPI reporting for the directly provided services of infusion therapy, pediatrics, pharmacy, & inpatient rehabilitation, the functions of transcription & utilization review, and the contracted services of biomedical engineering, laundry, & teleradiology.</p> <p>2. On 5/20/15 at 12:45 pm, A3, Director of Quality Risk Management, confirmed the above were not included in the QAPI program reports.</p>		<p>monthly on the Quality Dashboard by the responsible departmental director. The summary of data will be reported to the Quality Patient Safety Committee on a quarterly schedule. The data will then flow through the MEC to the BOT for final approval, review and recommendations. How are you going to prevent the deficiency from recurring in the future? The Director of Quality will review the data on the Quality Dashboard that will be reported on a quarterly schedule. The oversight of the Quality Patient Safety Committee will ensure that the data is collected and reported. There is a reporting schedule for the directors and is on the first tab on the X-cel document Quality Dashboard. It is labeled "Reporting Schedule". Reminders are sent prior to each monthly meeting to remind them of this reporting schedule. An administrative representative sits on the council so that any deficiency in reporting may be addressed at that level. Also, the Quality Dashboard is a document open for review at both the director and administrative levels. Who is going to be responsible for 1 and 2 above? The Quality Patient Safety Committee will require the Department Directors of those responsible for the services to collect the data. The director will attend and report this data to the Quality Patient Safety Council on a quarterly basis. The</p>		

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S 0406 Bldg. 00	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the</p>	S 0406	<p>Committee will review and make recommendations. Minutes from these meetings, as well as the actual PI Data is forwarded to the MEC and then to the BOT for further/final approval and recommendations. The Director of Quality Risk Management attends both the MEC and BOT meeting for any discussion or questions as related to the Quality Program reports. By what date are you going to have the deficiency corrected? The indicators were added and data collection began in the month of June. The data will be reported at the Quality Patient Safety Committee on a quarterly basis and on to MEC and then to the board for final approval, review and recommendations. Corrected 6-15-15.</p>	06/15/2015

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	<p>quality assessment and improvement program (QAPI) failed to evaluate all areas by not including 4 of 28 directly provided services (infusion therapy, pediatrics, pharmacy, & inpatient rehabilitation), 2 of 12 functions (transcription & utilization review), and 3 of 6 contracted services (biomedical engineering, laundry, & teleradiology).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 2014 & 2015 QAPI meeting minutes lacked evidence of quality assurance evaluation for the directly provided services of infusion therapy, pediatrics, pharmacy, & inpatient rehabilitation, the functions of transcription & utilization review, and the contracted services of biomedical engineering, laundry, & teleradiology. On 5/20/15 at 12:45 pm, A3, Director of Quality Risk Management, confirmed the above were not included in the QAPI program reports. 		<p>QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC</p> <p>15-1.4-2(a)(1) How are you going to correct the deficiency? Quality measures have been developed for the infusion therapy, pediatrics, pharmacy, inpatient rehab, transcription, utilization review, biomedical engineering, laundry & teleradiology. Data will be collected each month to track and evaluate these services. This data will be first documented monthly on the Quality Dashboard by the responsible departmental director. The summary of data will be reported to the Quality Patient Safety Committee on a quarterly schedule. The data will then flow through the MEC to the BOT for final approval, review and recommendations. How are you going to prevent the deficiency from recurring in the future? The Director of Quality will review the data on the Quality Dashboard that will be reported on a quarterly schedule. The oversight of the Quality Patient Safety Committee will ensure that the data is collected and reported. There is a reporting schedule for the directors and is on the first tab on the X-cel document Quality Dashboard. It is labeled "Reporting Schedule". Reminders are sent prior to each monthly meeting to remind them of this reporting schedule. An administrative representative sits on the council so that any</p>		

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S 0726 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)		deficiency in reporting may be addressed at that level. Also, the Quality Dashboard is a document open for review at both the director and administrative levels. Who is going to be responsible for 1 and 2 above? The Quality Patient Safety Committee will require the Department Directors of those responsible for the services to collect the data. The director will attend and report this data to the Quality Patient Safety Council on a quarterly basis. The Committee will review and make recommendations. Minutes from these meetings, as well as the actual PI Data is forwarded to the MEC and then to the BOT for further/final approval and recommendations. The Director of Quality Risk Management attends both the MEC and BOT meeting for any discussion or questions as related to the Quality Program reports. By what date are you going to have the deficiency corrected? The indicators were added and data collection began in the month of June. The data will be reported at the Quality Patient Safety Committee on a quarterly basis and on to MEC and then to the board for final approval, review and recommendations. Corrected 6-15-15.		

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	<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 facility failed to ensure unauthorized access to patient records for 4 cardboard boxes of medical records (MR) in one location (maintenance shop).</p> <p>Findings:</p> <p>1. Review of the policy & procedure (P&P) titled Secure Medical Record Storage indicated 1. Medical records must be properly filed and stored in a secure location(s) that safeguard from the following: b. Man made hazards such as theft, accidental loss, sabotage, etc. d. Unauthorized use, disclosure, and destruction. 2. Secure location means the location must ensure the integrity,</p>	S 0726	<p>S 0726 410 IAC 15-1.5-4(c)(7) (A)(B) Medical Record Services How are you going to correct the deficiency? The containers/boxes were removed from the Maintenance storeroom and reviewed by the medical records department and separated for storage in the Medical Records department and the remainder (outdated) were destroyed. May 20, 2015 How are you going to prevent the deficiency from recurring in the future? SMH now has Electronic Medical Record (EMR). Once the paper portion of the chart is sent to medical records, it is scanned into the EMR and the documents are destroyed. Medical Records no longer leave the department for</p>	05/20/2015

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S 0952 Bldg. 00	<p>security and protection of the records and are limited to access only by authorized individuals. The P&P was approved 9/2013.</p> <p>2. On 5/18/15 between 11:00 am and 12:00 pm during facility tour, in a storage aisle of the maintenance shop, in the presence of A1, Chief Executive Officer (CEO) and S8 (maintenance supervisor), 4 cardboard boxes were on shelves and labeled as follows: Path reports, path and lab, blood bank, & lab. Inside the boxes were multiple patients' medical records documentation.</p> <p>3. On 5/18/15 at 12:00 pm, A1 and S8 indicated maintenance personnel did not have authorized access to MRs and the records should not be in that location.</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 special training for these procedures</p>		<p>storage. Who is going to be responsible for the above requirements? The Director of the Medical Records Department over sees all of the functions of the department. By what date are you going to have the deficiency corrected? The medical records were relocated on May 20, 2015.</p>		

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	<p>in accordance with subsection (b)(6). Based on policy and procedure review, document review, and staff interview, the facility failed to administer blood transfusions in accordance with approved medical staff policies and procedures for 1 of 1 (patient #19) open patient medical record reviewed and 5 of 11 (patients #20-24) closed patient medical records reviewed.</p> <p>Findings:</p> <p>1. Policy #NUR 11.0011, Blood and Blood Product Administration, revised/reapproved 2/2014, indicated on pg: A. 3, under Patient Information section, point 1., "At a minimum, the patient's temperature, pulse and blood pressure are taken and recorded prior to, 15 minutes after initiating, and at the completion of a transfusion." B. 4, under Procedure section, point 6., "Evaluate pre-transfusion vital signs before obtaining blood to make sure transfusion can be performed (e.g. an elevated temperature may delay transfusion)..." C. 6, under Procedure section, point 20., "At the time of the 60 minute vital signs, evaluate transfusion progress for timeliness..."</p>	S 0952	<p>How are you going to correct the deficiency? The policy and procedure was reviewed. With input from nursing, CNO, lab director and the Medical Lab director, it has been updated to clarify and include a time frame for obtaining vs prior to obtaining the blood product. The Transfusion Administration Record (TAR) has been updated in Meditech to clearly indicate vs are required prior to obtaining blood and prior to initiating the blood product administration with a dedicated place to document these vital signs. How are you going to prevent the deficiency from recurring in the future? Education of staff regarding new TAR form changes and the required documentation. We currently monitor the number of transfusions completed without variances. We have added a PI monitor to track the completion of a Variance Transfusion Form for every variance that occurs. Who is going to be responsible for the above requirements? Nursing Directors will educate the staff on documentation. The Director of Lab will monitor for documentation variances and forward those variance to Nursing Directors for intervention. The Nursing Directors will review variance and complete and review the Transfusion Variance Form with the staff involved with the event. This will</p>	06/19/2015			

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	<p>2. Review of open and closed patient medical records on 5/19/15 and 5/20/15 at approximately 1000 hours and 1027 hours, confirmed:</p> <p>A. patient #19:</p> <p>a. received a transfusion of packed red blood cells (PRBCs) on 5/19/15 that was started at 0205 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 0205, which is not prior to the start of the transfusion.</p> <p>B. patient #20:</p> <p>a. received a transfusion of PRBCs on 5/6/15 that was started at 1438 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 1438, which is not prior to the start of the transfusion.</p> <p>c. the transfusion was stopped at 1654 and the 60 minute vital sign was recorded as 1700, which is 6 minutes after the transfusion was stopped.</p> <p>d. received another transfusion of PRBCs on 5/13/15 that was started at 1123 hours.</p> <p>e. the last recorded pre-transfusion vital signs were at 1123, which is not prior to the start of the transfusion.</p> <p>f. the transfusion was stopped at 1352 and the 60 minute vital sign was recorded as 1425, which is 33 minutes after the transfusion was stopped.</p> <p>C. patient #21:</p>		<p>include education, review of policies and progressive discipline as indicated. Complicance with this process will be monitored by the Lab Director and has been added to the Quality Dashboard under Blood Bank monitoring. The CNO is ultimately responsible for this process for nursing. She is on the Quality Patient Safety Committee where this data is reported on a Quartelry Basis. It is also available on the Quality Dashboard. By what date are you going to have the deficiency corrected? The Policy was updated on 6-18-15. The TAR was updated on 6-17-16. Education and implementation will be completed by 6-19-15. PI for completion of a Variance Form for every variance that occurs has been added to the Quality Dashboard for laboratory services. Data is being collected beginning with the month of June and will be reported at the July Quality Patient Safety Committee Meeting. Complete 6-19-15.</p>	

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	<p>a. received a transfusion of packed red blood cells (PRBCs) on 5/11/15 that was started at 1952 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 1952, which is not prior to the start of the transfusion.</p> <p>D. patient #22:</p> <p>a. received a transfusion of packed red blood cells (PRBCs) on 4/30/15 that was started at 2008 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 2008, which is not prior to the start of the transfusion.</p> <p>E. patient #23:</p> <p>a. received a transfusion of packed red blood cells (PRBCs) on 4/29/15 that was started at 1542 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 1542, which is not prior to the start of the transfusion.</p> <p>c. the transfusion was stopped at 1922 and the 60 minute vital sign was recorded as 1925, which is 3 minutes after the transfusion was stopped.</p> <p>F. patient #24:</p> <p>a. received a transfusion of packed red blood cells (PRBCs) on 4/28/15 that was started at 0131 hours.</p> <p>b. the last recorded pre-transfusion vital signs were at 0131, which is not prior to the start of the transfusion.</p>			

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S 1164 Bldg. 00	<p>3. Staff #26 (Lab Director) was interviewed on 5/19/15 at 3:14 PM, and confirmed the above-mentioned patients lacked pre-transfusion vital signs and/or 60 minute post-transfusion vital signs as required by facility policy and procedure.</p> <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. Based on documentation, observation, and interview, the hospital failed to ensure preventive maintenance for 8 pieces of equipment (hand bike, crutches, quad cane, walker, parallel bars, wooden stair set, floor scrubber, and patient beds)</p> <p>Findings: 1. Review of the policy & procedure</p>	S 1164	<p>How are you going to correct the deficiency? Preventive Maintenance work orders have been developed and implemented to ensure safety of the equipment used by our patients. How are you going to prevent the deficiency from recurring in the future? Preventive Maintenance work orders are entered in our electronic work order system that schedules the work order to be</p>	06/19/2015			

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	<p>(P&P) titled Preventative Maintenance(PM) indicated the purpose was to ensure equipment at the hospital is properly maintained and managed and procedure to include PM scheduled according to manufacturer's recommendations, area served by the equipment, condition of the equipment and experience of the maintenance department. The P&P was effective 12/17/14.</p> <p>2. On 5/18/15 at 12:00 pm during facility tour, in the presence of A1, Chief Executive Officer, A12, Medical Laboratory Technician, & S8, Mainentance Supervisor, the following was observed in the activities room: a hand bike, crutches, a walker, a quad cane, parallel bars, & wooden exercise stairs.</p> <p>3. Review of facility PM documents lacked evidence of PM for the following activities room equipment: hand bike, crutches, walker, quad cane, parallel bars, & wooden exercise stairs and lacked evidence of PM for the floor scrubber and patient beds.</p> <p>4. On 5/20/15 at 12:20 pm, A4, Director of Building Services, confirmed the above equipment did not have regular PM.</p>		<p>completed by the maintenance staff. The Director of Building Services will monitor the completion of the inspections.</p> <p>Who is going to be responsible for the above requirements? The Director of Building Services will be responsible for monitoring and maintaining the records for the preventive maintenance on the equipment. By what date are you going to have the deficiency corrected? PM work orders issued for the equipment identified during survey and will be completed by the end of day 6-19-15 and scheduled for annual PM.</p>	

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

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