

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000000	<p>This visit was for a full Federal survey following a Federal complaint survey with condition level deficiency.</p> <p>Facility Number: 004975</p> <p>Survey Date: 6-2/5-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Nurse Surveyor Supervisor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: clauglin 06/17/14</p>	A000000		
A000115	482.13 PATIENT RIGHTS			

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: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
	A hospital must protect and promote each patient's rights. Based on document review and staff interview, it was determined that the hospital failed to protect and promote the rights of each patient. The facility failed to ensure that each patient and/or the responsible party was informed of their rights prior to receiving care or prior to discharge (see A 0117), failed to ensure that patients and/or the responsible party was informed of whom to contact in order to file a grievance (see A 0118), failed to obtain patients' informed consent before administering blood transfusions (see A 0131), failed to ensure evidence that less restrictive interventions were determined ineffective prior to implementation of a restraint (see A 0164), failed to ensure modifications were made to the patients care plan after an episode of seclusion (see A 0166), failed to ensure a restraint order was obtained for the use of a physical restraint (see A 0168), failed to ensure an order for seclusion was time limited (see A0171), failed to ensure a patient placed in seclusion was monitored (see A0175), failed to ensure a 1-hour face-to-face was conducted after implementation of a seclusion order (see A 0178), failed to ensure staff were trained in the application of restraints (see A 0196) and failed to ensure that unlicensed direct	A000115	<p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.13-Patient Rights</p> <p>ID PREFIX TAG: A115</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/3/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital will protect and promote patient rights and will provide written information on these rights, including the Grievance process, to patients before care is rendered or before discontinuation of care.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: The Patient Rights, Patient Responsibilities, Grievance Procedure, Advanced Directives and Organ Donation, and "Special Message from Medicare" information will be placed in a packet and kept in a folder at the Registration Desk. All patients receiving services at Saint Catherine Regional Hospital must register at this desk before services are rendered, including direct admissions. This information, as well as the information posted in Registration and ED areas will be reviewed</p>	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>care staff who may restrain patients had training in first aid techniques and certification in the use of cardiopulmonary resuscitation (see A 0206).</p> <p>The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the protection and promotion of the patient rights.</p>		<p>and updated to include correct contact phone numbers. This packet will be given to all patients at the time of admission, or at the time any services are discontinued, and the patients will be given an opportunity to ask questions. The patients will be instructed to keep this copy for their future reference, or if they wish, they can leave their copy in a box by the door in the registration area, rather than throw it away. Registration staff will be educated on this information and the need to provide copies of it to all patients at time of admission or discharge from facility.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Rebecca Cook, Accounting Manager</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The Accounting Manager, who supervises the registration staff, will monitor the number of packets that are kept by the patients versus the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>number left in the box to monitor compliance. She will also periodically observe the registration process and monitor compliance. She will report her findings to the Quality Council monthly for 3 months, beginning in September 2014. At which time, the Quality Council will decide if continued monitoring is warranted.</p> <p>Step 1 Complete Complaint Data</p> <p>Patient Name : _____ _____ MD _____ Room # _____</p> <p>Address of contact person: _____ _____ _____</p> <p>Complaint Received from (Name): _____ _____</p> <p>Relationship: Patient Family/ S.O.(specify) _____</p> <p>Physician Staff Member Other (specify): _____</p> <p>Summarize Complaint: _____ _____ _____</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Date: _____ Forwarded form to Indicated Department (name of Dept.): _____</p> <p>Signature of Staff Member Completing Step 1 (name & title): _____</p> <p>Date: _____</p> <p>Step 2 Department Manager/Supervisor Review and Documentation</p> <p>Department Manager/Supervisor's Review Findings:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Immediate Action Taken (describe specific interventions below):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Issue Resolved <input type="checkbox"/> Issue Not Resolved <input type="checkbox"/></p> <p>(check any that apply):</p> <p>Administration Notified <input type="checkbox"/> MD <input type="checkbox"/></p> <p>Notified _____</p> <p>(name)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>(name) DQM Notified Social Worker Notified CCO Notified Legal Services Notified</p> <p>Date _____ Forwarded to CCO (name) _____</p> <p>Signature of Department Manager Completing Step 2: _____ _ Date: _____</p> <p>Step 3: CCO Review and Documentation</p> <p>Resolution satisfactory, forwarded to CEO. Date: _____</p> <p>Resolution <i>unsatisfactory</i>, returned to Dept. Date: _____</p> <p>Comments: _____ _____ _____ _____</p> <p>Signature and Title of CCO: _____</p> <p>Resolution satisfactory after further investigation requested, issue forwarded to CEO.</p> <p>Comments: _____ _____ _____</p> <p>Date: _____ Forwarded Completed Form to CEO _____</p> <p>Signature of CCO Completing Step 3: _____ Date: _____</p> <p>Step 4: CEO Review and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Documentation</p> <p>Findings: _____ _____</p> <p>Actions/Recommendations:</p> <p>Issue Resolved, Forward to DQM/Designee QC Subcommittee Convened</p> <p>Written Response Sent within 7 days</p> <p>Follow up letter if required Date: ____ Forwarded to DQM or designee (name) _____</p> <p>Signature of CEO Completing Step 4: _____ Date: _____</p> <p>Step 5: DQM or Designee Completes Documentation on the Complaint Log</p> <p>Signature of DQM or Designee Completing Step 5: _____ Date: _____</p> <p>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.</p> <p>On the last page of this document is the name and phone number of the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Facility Privacy Officer should you have questions about your privacy rights. You will also find the effective date of this document.</p> <p>WHO WILL FOLLOW THIS NOTICE – This notice describes our hospital’s practices and the physicians who provide services to patients at this hospital. It will also apply to any healthcare professional authorized to provide you with treatment and/or authorized to enter information into your hospital chart.</p> <p>MEDICAL INFORMATION – Each time you visit a hospital, physician, or other provider of health care, a record is made of your visit. We need this information to provide you with quality care and to comply with the law. Your health record is the physical property of the healthcare provider that compiles it; however, the information belongs to you. We are required by law to maintain the privacy of your health information and we are committed to doing so. We will abide by the terms of this notice as required by federal law.</p> <p>HOW WE USE AND DISCLOSE MEDICAL INFORMATION –</p> <p>- <u>Treatment</u> – Medical information is used to provide you with medical treatment. This information may be disclosed to physicians, nurses, technicians and other individuals who are involved in your care. Departments of the hospital may share information about you in order</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>to coordinate the things you need, such as prescription drugs, lab tests and X-rays. For example, a physician treating you for a broken bone will need to know if you are diabetic as this may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be provided for you.</p> <p><u>Payment</u> – We use and disclose medical information about you so that we can bill and collect payment. This could include an insurance company or a third party. If you are covered by health insurance your health plan may need information from us about a surgery or other procedure you had, or will have, before they will pay us. We may disclose information about you for the payment activities of another healthcare provider.</p> <p><u>Health Care Operations</u> – Your medical information may be used or disclosed for purposes of our day-to-day operations. These activities are necessary to operate the hospital and to monitor the quality of care our patients receive. Examples would include to assess your satisfaction with our services; remind you of appointments; to tell you of possible treatment alternatives; evaluation of the treatment you received by our staff; to work with health oversight organizations which would include audits, investigations, inspections and licensure; and to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>combine information about you with other patients to determine what additional services should be provided.</p> <p><u>Clergy</u> – In accordance with the law, we may disclose your name, location in the facility, religious affiliation and general condition to members of the clergy, but only if you have not objected to this information being released.</p> <p><u>Individuals Involved in Care or Payment for Your Care</u> – We may disclose your medical information to a family member or friend who will be involved in your care.</p> <p><u>Law Enforcement</u> – Subject to certain restriction, we may disclose information required by law enforcement.</p> <p>-</p> <p>-</p> <p>-</p> <p><u>Legal Requirements</u> – We disclose patient information to comply with both state and federal laws. For example, we are required to report to the state anytime a patient has certain diseases, for example, tuberculosis. Other examples of required reporting would involve cases involving abuse, negligence or domestic violence; Workers Compensation Agents; Food and Drug Administration; Correctional institutions regarding inmates; to comply with court orders, subpoenas, or other administrative</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>process; organ procurement organizations; and to reports to the state all births and deaths.</p> <p><u>Medical Examiners, Coroners, and Funeral Directors</u> – We may disclose information to these entities when necessary for them to carry out their job responsibilities.</p> <p><u>Military and Veterans</u> – If you are, or have been, a member of the armed forces we may disclose information about you as required by military authorities.</p> <p><u>National Security</u> – We may release patient information to authorized federal officials for matters related to national security.</p> <p><u>Patient Directory</u> – You have the opportunity to be included in the patient directory or you may “opt out.” If you are in the patient directory and someone asks about you by name then we may provide verification that you are a patient, your location in the facility, and your general condition (for example, fair, stable, etc.). Should you decide to opt out of the directory then anyone asking for you will be given no information.</p> <p><u>Serious Threats to Health or Safety</u> – We may disclose information about you when necessary to prevent a serious threat to your health and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>safety as well as the health and safety of the public.</p> <p><u>Public Health Risks</u> – we disclose information to report reactions to medications or medical products; to notify people of recalls; to notify people who may have been exposed to a disease or at risk of contracting or spreading a disease; and to report certain injuries as gunshots or knife wounds.</p> <p>YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU – You have the following rights with regard to your health information. Please contact the privacy officer to obtain the appropriate forms for exercising these rights.</p> <p><u>To Inspect and Copy</u> – In most cases you have the right to inspect and to obtain a copy of the health information that may have been used to make decisions about your care. A fee may be charged if you obtain a copy of your records. The law provides in limited circumstances you may be denied access to this information.</p> <p><u>To Request an Amendment to Your Medical Record</u> – If you believe that the information we have about you is incorrect or is incomplete, you have the right to request an amendment to the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>information. You have this right for as long as we have the information.</p> <p><u>To Request Restrictions</u> – You have the right to request that we restrict or limit the medical information we use or disclose about you for treatment, payment, or healthcare operations. The law states we are not required to comply with your request; however, if we do then we will comply unless the information is needed to provide you with emergency care.</p> <p><u>To Request Confidential Communications</u> – You have the right to request that we communicate with you about medical matters in a certain way or at a particular location. We will accommodate all reasonable requests; however, you are not allowed to limit the way we can contact you in order to avoid your responsibility to pay us for the services rendered to you.</p> <p><u>To Request an Accounting of Disclosures</u> – You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. We are not required to provide for an accounting which took place before</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>April 14, 2003.</p> <p>OTHER USES OF YOUR MEDICAL INFORMATION -</p> <p>If we wish to disclose medical information about you for a reason not covered by treatment, payment, healthcare operations, legal requirements or other disclosures as set forth in this notice, we will seek your written authorization. If you provide us written authorization to use or disclose medical information about you, you may revoke it at any time by doing so in writing. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.</p> <p>CHANGES TO THIS NOTICE -</p> <p>We reserve the right to change this notice and our policies at any time. If our policies change and we make changes to our Notice then we will post the new Notice in a public area. You can request a copy of our Notice at any time.</p> <p>COMPLAINTS -</p> <p>If you believe your privacy rights have been violated, you may file a complaint with the Facility Privacy Officer or with the Secretary of the Department of Health and Human Services in Washington, D.C. To file a complaint you will need to contact the Facility Privacy Officer</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>whose name and phone number is on the following page. All complaints must be submitted in writing.</p> <p>You will not be penalized for filing a complaint.</p> <p>PRIVACY OFFICER</p> <p>If you have questions, requests, or complaints, please contact:</p> <p>Holly Hoffman, RHIA, HIM Director, 2200 Market St, Charlestown, IN 47111 (812-256-7685) Chief Executive Officer, 2200 Market St, Charlestown, IN 4711 (812-256-7491)</p> <p>The Effective Date of this Notice is April 14, 2003.</p> <p>Privacy Notice Written Acknowledgment</p> <p>Patient Name: _____</p> <p>_____ Medical Record #: _____</p> <p>(Last) _____ (First) _____ (Middle) _____</p> <p>- - q I have received the Notice of Privacy Practices, effective date of _____.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>patient and/or the responsible party was informed of their rights prior to receiving care or prior to discharge for 5 of 5 medical records (MR) reviewed (Patient #1, 2, 6, 7 & 9).</p> <p>Findings include:</p> <p>1. Review of the Registration Consent Form indicated the following: "Patient Information: As an adult patient (18 years or older or an emancipated minor) receiving services for Acute care, Behavioral Health services, Emergency services, Observation and/or Outpatient surgery, I have received the information/forms listed below, the information has been fully explained to me and I have had the opportunity to have questions answered. - Patient Rights/patient Grievance Procedures - Patient Responsibilities - Advance Directives Information/Your Right to Decide - Organ Donation"</p> <p>2. On 06-05-14 at 0942 hours, staff #50, registration clerk, confirmed that when patients are registering and consenting for treatment, no copies of the Patient Rights/Patient Grievance Procedures, Patient Responsibilities, Advance Directives Information/Your Right to</p>		<p>DEFICIENCY WILL BE CORRECTED: 7/3/2014 WHAT IS THE PLAN OF CORRECTION: Information on Patient Rights, Responsibilities, Grievance Procedure, Advanced Directives, and Organ Donation will be provided to patients in advance of or when discontinuing any provision of care. HOW THE PLAN OF CORRECTION WILL OCCUR: The Patient Rights, Patient Responsibilities, Grievance Procedure, Advanced Directives and Organ Donation information will be updated to reflect the facilities current Policies and Procedures. A copy of this information will be placed in a packet and kept in a folder at the Registration desk and Nurses Stations. This packet will be provided to all patients at the time of admission or at the time any services are discontinued. Registration staff and nursing staff will be educated on this information and the need to provide copies of it at time of admission and/or discharge from facility. WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Rebecca Cook, Accounting Manager WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14 HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The Accounting</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Decide, Organ Donation are given.</p> <p>3. Review of patient #1, 2, 6, 7 & 9's MR indicated that each was a Medicare patient and each MR lacked documentation of receiving the "Important Message From Medicare" on admission & prior to discharge.</p> <p>4. On 06-05-14 at 1030 hours, staff #51, registration manager, confirmed that the Important Message From Medicare notice is not given to patients.</p> <p>5. On 06-05-14 at 1040 hours, staff #52, case manager, confirmed that the Important Message From Medicare notice is not given to patients.</p>		<p>Manager, who supervises the registration staff, will monitor the number of packets that are kept by the patients versus the number left in the box to monitor compliance. She will also periodically observe the registration process and monitor compliance. She will report her findings to the Quality Council monthly for 3 months, beginning in September 2014. At which time, the Quality Council will decide if continued monitoring is warranted.</p> <p>Step 1 Complete Complaint Data</p> <p>Patient Name : _____ _____ MD _____ Room # _____</p> <p>Address of contact person: _____ _____ _____</p> <p>Complaint Received from (Name): _____ _____</p> <p>Relationship: Patient Family/ S.O.(specify) _____</p> <p>Physician Staff Member Other (specify): _____</p>	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>(name)</p> <p>(name)</p> <p>DQM Notified Social Worker Notified CCO Notified Legal Services Notified</p> <p>Date _____ Forwarded to CCO (name) _____</p> <p>Signature of Department Manager Completing Step 2: _____</p> <p>Date: _____</p> <p>Step 3: CCO Review and Documentation</p> <p>Resolution satisfactory, forwarded to CEO. Date: _____</p> <p>Resolution <i>unsatisfactory</i>, returned to Dept. Date: _____</p> <p>Comments: _____ _____ _____</p> <p>Signature and Title of CCO: _____ _____</p> <p>Resolution satisfactory after further investigation requested, issue forwarded to CEO.</p> <p>Comments: _____ _____ _____</p> <p>Date: _____ Forwarded Completed Form to CEO _____</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Signature of CCO Completing Step 3: _____ Date: _____</p> <p>Step 4: CEO Review and Documentation</p> <p>Findings: _____ _____</p> <p>Actions/Recommendations: Issue Resolved, Forward to DQM/Designee QC Subcommittee Convened</p> <p>Written Response Sent within 7 days</p> <p>Follow up letter if required Date: _____ Forwarded to DQM or designee (name) _____</p> <p>Signature of CEO Completing Step 4: _____ Date: _____</p> <p>Step 5: DQM or Designee Completes Documentation on the ComplaintLog</p> <p>Signature of DQM or Designee Completing Step 5: _____ Date: _____</p> <p>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>On the last page of this document is the name and phone number of the Facility Privacy Officer should you have questions about your privacy rights. You will also find the effective date of this document.</p> <p>WHO WILL FOLLOW THIS NOTICE – This notice describes our hospital’s practices and the physicians who provide services to patients at this hospital. It will also apply to any healthcare professional authorized to provide you with treatment and/or authorized to enter information into your hospital chart.</p> <p>MEDICAL INFORMATION – Each time you visit a hospital, physician, or other provider of health care, a record is made of your visit. We need this information to provide you with quality care and to comply with the law. Your health record is the physical property of the healthcare provider that compiles it; however, the information belongs to you. We are required by law to maintain the privacy of your health information and we are committed to doing so. We will abide by the terms of this notice as required by federal law.</p> <p>HOW WE USE AND DISCLOSE MEDICAL INFORMATION –</p> <p>Treatment – Medical information is used to provide you with medical treatment. This information may be disclosed to physicians, nurses, technicians and other individuals</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>who are involved in your care. Departments of the hospital may share information about you in order to coordinate the things you need, such as prescription drugs, lab tests and X-rays. For example, a physician treating you for a broken bone will need to know if you are diabetic as this may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be provided for you.</p> <p>Payment – We use and disclose medical information about you so that we can bill and collect payment. This could include an insurance company or a third party. If you are covered by health insurance your health plan may need information from us about a surgery or other procedure you had, or will have, before they will pay us. We may disclose information about you for the payment activities of another healthcare provider.</p> <p>Health Care Operations – Your medical information may be used or disclosed for purposes of our day-to-day operations. These activities are necessary to operate the hospital and to monitor the quality of care our patients receive. Examples would include to assess your satisfaction with our services; remind you of appointments; to tell you of possible treatment alternatives; evaluation of the treatment you received by our staff; to work with</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>health oversight organizations which would include audits, investigations, inspections and licensure; and to combine information about you with other patients to determine what additional services should be provided.</p> <p>Clergy – In accordance with the law, we may disclose your name, location in the facility, religious affiliation and general condition to members of the clergy, but only if you have not objected to this information being released.</p> <p>Individuals Involved in Care or Payment for Your Care – We may disclose your medical information to a family member or friend who will be involved in your care.</p> <p>Law Enforcement – Subject to certain restriction, we may disclose information required by law enforcement.</p> <p>- - -</p> <p>Legal Requirements – We disclose patient information to comply with both state and federal laws. For example, we are required to report to the state anytime a patient has certain diseases, for example, tuberculosis. Other examples of required reporting would involve cases involving abuse, negligence or domestic violence; Workers Compensation Agents; Food and Drug Administration;</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Correctional institutions regarding inmates; to comply with court orders, subpoenas, or other administrative process; organ procurement organizations; and to reports to the state all births and deaths.</p> <p><u>Medical Examiners, Coroners, and Funeral Directors</u> – We may disclose information to these entities when necessary for them to carry out their job responsibilities.</p> <p><u>Military and Veterans</u> – If you are, or have been, a member of the armed forces we may disclose information about you as required by military authorities.</p> <p><u>National Security</u> – We may release patient information to authorized federal officials for matters related to national security.</p> <p><u>Patient Directory</u> – You have the opportunity to be included in the patient directory or you may “opt out.” If you are in the patient directory and someone asks about you by name then we may provide verification that you are a patient, your location in the facility, and your general condition (for example, fair, stable, etc.). Should you decide to opt out of the directory then anyone asking for you will be given no information.</p> <p><u>Serious Threats to Health or</u></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Safety – We may disclose information about you when necessary to prevent a serious threat to your health and safety as well as the health and safety of the public.</p> <p>Public Health Risks – we disclose information to report reactions to medications or medical products; to notify people of recalls; to notify people who may have been exposed to a disease or at risk of contracting or spreading a disease; and to report certain injuries as gunshots or knife wounds.</p> <p>YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU – You have the following rights with regard to your health information. Please contact the privacy officer to obtain the appropriate forms for exercising these rights.</p> <p>To Inspect and Copy – In most cases you have the right to inspect and to obtain a copy of the health information that may have been used to make decisions about your care. A fee may be charged if you obtain a copy of your records. The law provides in limited circumstances you may be denied access to this information.</p> <p>To Request an Amendment to Your Medical Record – If you believe that the information we</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>have about you is incorrect or is incomplete, you have the right to request an amendment to the information. You have this right for as long as we have the information.</p> <p><u>To Request Restrictions</u> – You have the right to request that we restrict or limit the medical information we use or disclose about you for treatment, payment, or healthcare operations. The law states we are not required to comply with your request; however, if we do then we will comply unless the information is needed to provide you with emergency care.</p> <p><u>To Request Confidential Communications</u> – You have the right to request that we communicate with you about medical matters in a certain way or at a particular location. We will accommodate all reasonable requests; however, you are not allowed to limit the way we can contact you in order to avoid your responsibility to pay us for the services rendered to you.</p> <p><u>To Request an Accounting of Disclosures</u> – You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. We are not required to provide for an accounting</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>which took place before April 14, 2003.</p> <p>OTHER USES OF YOUR MEDICAL INFORMATION -</p> <p>If we wish to disclose medical information about you for a reason not covered by treatment, payment, healthcare operations, legal requirements or other disclosures as set forth in this notice, we will seek your written authorization. If you provide us written authorization to use or disclose medical information about you, you may revoke it at any time by doing so in writing. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.</p> <p>CHANGES TO THIS NOTICE -</p> <p>We reserve the right to change this notice and our policies at any time. If our policies change and we make changes to our Notice then we will post the new Notice in a public area. You can request a copy of our Notice at any time.</p> <p>COMPLAINTS -</p> <p>If you believe your privacy rights have been violated, you may file a complaint with the Facility Privacy Officer or with the Secretary of the Department of Health and Human Services in Washington, D.C. To file a complaint you will need to contact the Facility Privacy Officer</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>whose name and phone number is on the following page. All complaints must be submitted in writing.</p> <p>You will not be penalized for filing a complaint.</p> <p>PRIVACY OFFICER</p> <p>If you have questions, requests, or complaints, please contact:</p> <p>Holly Hoffman, RHIA, HIM Director, 2200 Market St, Charlestown, IN 47111 (812-256-7685) Chief Executive Officer, 2200 Market St, Charlestown, IN 4711 (812-256-7491)</p> <p>The Effective Date of this Notice is April 14, 2003.</p> <p>Privacy Notice Written Acknowledgment</p> <p>Patient Name: _____</p> <p>__ Medical Record #: _____</p> <p>(Last) (First) (Middle)</p> <p>- - q I have received the Notice of Privacy Practices, effective date of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>_____. (mm/dd/yy)</p> <p>_____</p> <p>_____</p> <p>Signature of Patient/Parent/Legal Guardian</p> <p>Date</p> <p>_____</p> <p>_____</p> <p>Relationship to Patient</p> <p style="text-align: right;">Witness</p> <p style="text-align: center;">Documentation of Good Faith Effort</p> <p>q Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.</p> <p>q Patient/Parent/Legal Guardian stated they had already</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>infectious disease(s), including but not limited to, Hepatitis and Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV), if a physician orders for diagnostic purposes. I also acknowledge the emergency room physicians are contracted staff, and are not employees of the Hospital.</p> <p>MEDCAL AND SURGICAL TREATMENT: I agree and understand that all physicians treating the patient or me in any way are responsible and liable for their own acts or omission and Saint Catherine Regional Hospital is not responsible or liable for the act and omissions of the aforementioned. I am aware that the practice of medicine is not an exact science and further state that no guarantee has been or can be made as to the results of the treatments of examinations in the hospital.</p> <p>FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I agree that I am responsible for payment of my hospital bill. Payment of any portion of my bill not covered by a third party payer is due upon discharge from the hospital unless the hospital has agreed to other arrangements. I agree to the assignment of all third party payer benefits to the hospital and to any physician and independent practitioners for all charges for services, which are not covered or paid by any third party payer regardless of services, or medically</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000118	<p>482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. Based on document review, interview & observation, the facility failed to ensure that patients and/or the responsible party was informed of whom to contact in order to file a grievance.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Patient Rights & Responsibilities indicated the following: "- the patient, or when appropriate, the patient's representative has the right to file a verbal or written dispute, grievance or conflict by contacting any employee, administrative staff member, or by contacting the Director of Quality Management at 256-7660."</p> <p>2. Review of the Registration Consent Form indicated the following:</p>	A000118	<p>necessary. After reasonable notice, any unpaid account may be turned over to a collection agency and /or attorney for collection. Should it be necessary for the hospital to pursue collection, I agree to pay all reasonable collection costs, including court costs and attorney fees incurred by the hospital in collecting account.</p> <p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.13-Patient Rights</p> <p>ID PREFIX TAG: A118</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/3/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Information on the Grievance Procedure will be provided to patients in advance of or when discontinuing any provision of care.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: The Grievance Procedure will be updated to reflect the facilities current Policies and Procedures. An explanation of this Grievance Procedure will be included in the Patient's Rights information sheet</p>	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>"Patient Information: As an adult patient (18 years or older or an emancipated minor) receiving services for Acute care, Behavioral Health services, Emergency services, Observation and/or Outpatient surgery, I have received the information/forms listed below, the information has been fully explained to me and I have had the opportunity to have questions answered.</p> <ul style="list-style-type: none"> - Patient Rights/patient Grievance Procedures - Patient Responsibilities - Advance Directives Information/Your Right to Decide - Organ Donation" <p>3. On 06-05-14 at 0942 hours, staff #50, registration clerk, confirmed that when patients are registering and consenting for treatment, no copies of the Patient Rights/Patient Grievance Procedures, Patient Responsibilities, Advance Directives Information/Your Right to Decide, Organ Donation are given.</p> <p>4. On 06-05-14 at 0940 hours, by the registration area, a poster was hanging labeled as "Patient Rights & Responsibilities". The poster lacked documentation that a grievance may be lodged with the state agency including the contact information of the state agency.</p>		<p>which is placed in a packet and kept in a folder at the Registration desk and Nurses Stations. This packet will be provided to all patients at the time of admission or at the time any services are discontinued. It will also be posted in the Registration area. Registration staff and nursing staff will be educated on this information and the need to provide copies of it at time of admission and discharge from facility.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Rebecca Cook, Accounting Manager</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The Accounting Manager, who supervises the registration staff, will monitor the number of packets that are kept by the patients versus the number left in the box to monitor compliance. She will also periodically observe the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>registration process and monitor compliance. She will report her findings to the Quality Council monthly for 3 months, beginning in September 2014.</p> <p>Quality Council Agenda Tuesday August 19, 2014 At 1300</p> <p>Item</p> <p>Presenter</p> <p>1) Approval of Minutes Group</p> <p>2) Old Business-</p> <ul style="list-style-type: none"> · CPI OR BEHAVIOR MANAGEMENT TRAINING FOR EMPLOYEES WHO WORK ON BHS · BODY MECHANICS TRAINING FOR BHS EMPLOYEES DUE TO INCREASED EMPLOYEE INJURIES. · ER POLICY-NO DC UNTIL TEST RESULTS ARE BACK · UR ISSUE-MD ADMISSION ORDERS TO SUPPORT BILLING · CMS AND ISDH SURVEY JUNE 2014 AND THE PLAN OF CORRECTION 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>3) Quality Reports</p> <p>QUALITY REPORTS:</p> <p>RADIOLOGY</p> <ol style="list-style-type: none"> 1. Radiology 2. Tele-radiology 3. Ultrasound 4. CT Scanner 5. Mammography 6. MRI · In-house · Contracted 7. Nuclear Medicine <p>LABORATORY</p> <ol style="list-style-type: none"> 1. In-house 2. Ref Lab 3. Blood bank 4. Respiratory Care 5. Sleep lab <p>FACILITIES</p> <ol style="list-style-type: none"> 1. Bioengineering-Contracted 2. Biohazard Waste Hauler 3. Central Sterile 4. Dietetic service <ol style="list-style-type: none"> 1. In-house 2. Contracted 5. Housekeeping 6. Linen Services 7. Maintenance 8. Security <p>MEDICAL RECORDS</p> <ol style="list-style-type: none"> 1. Transcription 2. Delinquencies <p>NURSING</p> <ol style="list-style-type: none"> 1. Geriatric Psych 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			2.DC Planning/SS 3.Utilization Review 4.BHS Laundry 5.Chart audits ER DEPARTMENT 1.PICC Services 2.Physical Therapy 3.Response to Patient Emergency 4.Speech Pathology 5.ER Dept 6.Infusion Therapy PHARMACY 1.Medication Errors QUALITY/RISK MGT 1.Event reports 2.Reportable Events 3.Medical Errors BUSINESS OFFICE 1.Registration packet given to all patients INFECTION PREVENTION LISA M.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			CLARK D.	
			DAVE M.	
			CAROL B.	
			BETH F.	
			KELLI B.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>BILL P.</p> <p>CHRISSY P.</p> <p>REBECCA (to begin 9/14)</p> <p>CHRISSYP.</p> <p>4) New Business –</p> <p>5) Next Meeting Date- TO BE DETERMINED</p> <p>6) Adjournment</p> <p>Read and Sign Date: _____</p> <p>REGISTRATION PACKETS:</p> <p>I understand that <u>EVERY</u> patient that is registered for services at Saint Catherine Regional Hospital must be <u>GIVEN</u> a packet which contains; Patient Rights,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Patient Responsibilities, Grievance Process, Information on Organ Donation, Advanced Directives and an Important Message from Medicare. The patient can keep the packet or put it in a box located in the registration area, on their way out. This includes patients going directly to the units as a direct admission. The consent form signature is the patient's attestation that they received the packet.</p> <p style="text-align: center;">PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
--------------------	--	---------------	---	----------------------

A000131	<p>482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.</p> <p>The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p> <p>Based on blood transfusion policy reviews, transfusion document chart reviews and staff interview, the hospital failed to obtain patients' informed consent before administering blood transfusions in accordance with approved medical staff policies and procedures for three (Patient #9, #17 and #18) of twenty patients.</p> <p>Findings include:</p> <p>1. On 6/03/14 at 1:40 p.m., review of the laboratory policy, "Blood and Blood Product Administration", revised 3/12, read: "Each person must initial or sign appropriate forms assuring that all identifiers match and are acceptable."</p> <p>2. On 6/04/14 at 2:00 p.m., review of</p>	A000131	<p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.13-Patient Rights</p> <p>ID PREFIX TAG: A131</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/3/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital will obtain informed consent prior to the rendering of any care, including but not limited to, the transfusion of blood or blood products. All blood or blood products administered at Saint Catherine Regional Hospital have a signed consent. This consent form will be located in the EHR.</p> <p>HOW THE PLAN OF</p>	07/03/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>twenty patients receiving blood units indicated six of these received-units did not have signed consent, per policy, including:</p> <p>Patient #9 Unit administered on 10/10/13 at 0725 and Unit administered on 10/10/14 at 0820 had been administered without benefit of a signed patient consent.</p> <p>Patient #17 Unit administered on 6/28/13 at 1630 had been administered with no documentation of a signed patient consent. Unit administered on 6/28/13 at 2038 had also been administered with no documentation of a signed patient consent.</p> <p>Patient #18 Unit administered on 5/23/13 at 1025 and Unit administered on 5/23/13 at 1351 had each been administered without benefit of a signed patient consent.</p> <p>3. On 6/03/14 at 4:30 p.m., staff member #5 (registered nurse) acknowledged that missing signed consents for the above-listed patient blood units was not available for review.</p>		<p>CORRECTION WILL OCCUR: The consent form for Blood or Blood product administration is part of the EHR. This consent form will be signed by the patient using an electronic signature pad and stored in the EHR. This consent form will be printed and taken to the lab for product pick up. No blood or blood product will be released by the MLT in the Lab without this signed consent form. The copy of this consent form may be maintained in the lab for reference; however the electronic image of the signed document will remain a part of the patient's legal record within the EHR.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C. Perra RN, NE; Kevin McLaughlin, IT; Clark Daniels, Lab Director; Beth Fisher RN, Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 6/20/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: All consent</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>forms will be on the Empower EHR system and be signed by the patient using an electronic signature pad. If paper consent forms are necessary, they will be sent to medical records to be scanned into the patient's EHR. No blood or blood product will be released from the blood bank without a copy of the signed consent provided to the MLT. The lab director will monitor and track compliance with consent forms and report his findings to the Quality Council during the Quality Council Meeting every month. A Transfusion Report will be completed by the House Supervisor with each administration of blood or blood products, which will include verification of signed consent form.</p> <p>SUPERVISOR TRANSFUSION REPORT</p> <p>DATE:TIME: PATIENT NAME: PATIENT NUMBER: INT SUPERVISOR SIGNATURE: 1. MD ORDER A. Product Specified B. How many units specified C. Infusion rate/duration if outside the recommended 2-4 hours for PRBC OR 30-60 min for FFP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>D. Reason for transfusion in MD order or documented by nurse</p> <p>2. CONSENT FORM SIGNED</p> <p>A. Visually verified signed consent form</p> <p>B. Checked on the "RELEASE FROM BLOOD BANK" section of the transfusion record</p> <p>3. TRANSFUSION RECORD</p> <p>A. SECTION I</p> <p>1. Patient sticker/label in the right hand corner</p> <p>2. Top "Nursing" section completed without holes</p> <p>a. If previous transfusion reaction noted- documentation that MD was notified</p> <p>b. Nursing signature for "Request completed by" section</p> <p>B. SECTION II</p> <p>1. Lab section completed with no holes, including date and time, and signed by Lab Tech</p> <p>C. SECTION III</p> <p>1. RELEASE FROM BLOOD BANK</p> <p>a. Lab Tech signature with date and time at the top</p> <p>b. RN signature for release</p> <p>c. "Consent Form Completed" checked on transfusion record</p> <p>d. 2 nurse verification at bedside signed-one signature is RN</p> <p>2. UNIT APPEARANCE</p> <p>a. "Acceptable" or "Unacceptable" marked</p> <p>b. "Pre" time must be before the "start" time</p> <p>1. Any abnormal vital sign reported to the MD and documented</p> <p>c. "Start" time is within 30 minutes</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>of the "Release from Blood Bank" time</p> <p>d. 15 minute vitals are done exactly 15 minutes after start time</p> <p>e. "Post" vital signs are done within 30 minutes of completion time.</p> <p>f. "Completion" time is documented</p> <p>g. Completion time is within 4 hours of start time for PRBC and 30-60 minutes for FFP</p> <p>h. "Amount Infused" is completed</p> <p>3. POST TRANSFUSION</p> <p>a. "Reaction" section completed</p> <p>b. If reaction noted, Each step (1-6) are followed and documented in the clinical record appropriately</p> <p>c. RN took the completed transfusion record to the lab and signed the form with the MT/MLT</p> <p>d. Second page of transfusion record given to lab</p> <p>MEETING MINUTES</p> <p>DATE</p> <p>Time:</p> <p>Location:</p> <p>Members Present:</p> <p>Members Absent:</p> <p>AGENDA ITEM</p> <p>APPROVAL OF MINUTES</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>MONTH APPROVED</p> <p>FIRST:</p> <p>SECOND:</p> <p>OLD BUSINESS RESPONSIBLE PARTY DISCUSSION/FINDINGS CONCLUSIONS/RECOMMENDATIONS</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000164	<p>482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Based on document review and staff interview, the facility failed to ensure evidence that less restrictive interventions were determined ineffective prior to implementation of a restraint in 1 (patient #26) of 1 instance of a physical restraint.</p> <p>Findings include:</p> <p>1. Review of patient #26 (med/surg patient) medical record indicated the following: (A) Nurse notes document at 0025 and</p>	A000164	<p>STANDING ITEMS RESPONSIBLE PARTY DISCUSSION/FINDINGS CONCLUSIONS/RECOMMENDATIONS QUALITY REPORTS: RADIOLOGY 1. Radiology 2. Tele-radiology 3. Ultrasound 4. CT Scanner 5. Mammography 6. MRI In-house</p> <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A164 DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014 WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint.</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>amended at 0035 on 4/25/14 indicated the patient had been physically held down by two (2) male staff members after he/she was physically and verbally "violent"</p> <p>(B) The medical record lacked evidence that less restrictive interventions were attempted prior to the implementation of the physical restraint.</p> <p>2 Facility policy titled "Restraint Use-Medical and Behavioral" last reviewed/revised 4/14 stated on page 3: "10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:.....The less restrictive alternative(s) to restraint considered....."</p> <p>3. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>HOW THE PLAN OF CORRECTION WILL OCCUR: The Policy and Procedure for the application of Restraints on a patient will be reviewed and updated if necessary to ensure that less restrictive measures are attempted prior to the application of any restraint. All nursing staff will be educated on the Policy and Procedure for the application of any restraint and the required documentation and follow up that is necessary. Any nurse applying a restraint or initiating seclusion will be responsible to notify the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation has been completed.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 6/20/14</p> <p>HOW THE DEFICIENCY</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>REOCCURRENCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure for Physical or Chemical restraints application at the time the restraint is initiated. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>Read and Sign Date: _____</p> <p>Review the Policy: Restraint Use-Medical and Behavioral</p> <p>I have read and understand the Restraint Use-Medical and Behavioral Policy. I understand that it is the nurse's responsibility to notify the House Supervisor if he/she is utilizing a restraint, either chemical or physical, regardless if it is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Medical or behavioral in nature. I understand that it is the House Supervisor's responsibility to verify proper adherence to the Policy and Procedure and to check that the proper documentation is done, notify the Unit Director, and ensure the MD order is complete and includes a time limitation. I also understand that I am NOT to participate in the application of or care of a restrained patient if I do not have documentation of current BLS or First Aid training. I acknowledge that a restraint is NEVER to be used as a form of coercion, discipline, convenience, or retaliation by staff and pledge to report any deviation from Policy and Procedure that I witness to my immediate supervisor or to the Quality Director at Ext 568.</p> <p style="text-align: center;">PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p style="text-align: center;">1</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			2	
			3	
			4	
			5	
			6	
			7	
			8	
			9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			10	
			11	
			12	
			13	
			14	
			15	
			16	
			SAINT CATHERINE REGIONAL HOSPITAL	
			SUBJECT:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Restraint Use-Medical and Behavioral</p> <p>PAGE: 1 DEPARTMENT: Administration-PC -</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14</p> <p>- Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy: · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>purposes (Refer to Attachment A for examples of restraint and immobilization not considered restraint.)</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode <p>Procedure:</p> <p>A. Medical restraint</p> <ol style="list-style-type: none"> 1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint). 2. Indications: Prior to the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000166	<p>482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. Based on document review and staff interview, the facility failed to ensure modifications were made to the patients care plan after an episode of seclusion in 1 instance (patient #23).</p> <p>Findings include:</p> <p>1. Review of patient #23 medical record indicated the following: (A) An order was written for seclusion at 0057 on 12/10/13 and the patient was placed in seclusion. (B) The medical record lacked evidence that the care plan was modified after the episode of seclusion.</p>	A000166	<p>registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation. 7. Initial in-person physic</p> <p>CMS PLAN OF CORRECTION 42-CFR §482.13-Patient Rights ID PREFIX TAG: A166 DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014 WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint. HOW THE PLAN OF</p>	07/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>2. Facility policy titled "RESTRAINT & SECLUSION" last reviewed/revised 12/09 stated on page 8: "The use of restraints, (both physical and drugs used as a restraint)/seclusion is done in accordance with a written modification to the patient's plan of care....."</p> <p>2. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>CORRECTION WILL OCCUR: All nursing staff will be educated on the Policy and Procedure titled "Restraint Use-Medical and Behavioral" for the application of any restraint and the required documentation and follow up that is necessary. The Restraint Policy and Procedure for our facility has been revised and updated to include the revision of the patient's Healthcare Plan to reflect the use of the restraint or seclusion. This revised Policy and Procedure will be implemented as an Interim Policy and Procedure until it can be approved by the Board of Directors, at the next Board of Directors meeting. Any nurse applying a restraint or initiating seclusion will be responsible for notifying the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation has been completed. The house Supervisor will then notify the Unit director/Manager who will also review the record for compliance with the Policy and Procedure.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: Restraint Use-Medical and Behavioral</p> <p>PAGE: 1 DEPARTMENT: Administration-PC -</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14 -</p> <p>Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Scope:</p> <p>The following are not considered restraint under this policy:</p> <ul style="list-style-type: none"> · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes <p>(Refer to Attachment A for examples of restraint and immobilization not considered restraint.)</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>but no longer than 24 hours after the episode</p> <p>Procedure:</p> <p>A. Medical restraint</p> <p>1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint).</p> <p>2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation.</p> <p>7. Initial in-person physician assessment within 24 hours of initiation: The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>that evaluation.</p> <p>8. Ongoing in-person physician assessments and continuation of restraint orders: The treating physician will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated.</p> <p>9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained.</p> <p>10. Patient Monitoring: Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible.</p> <p>11. Documentation: The following will be documented in the medical record whenever medical restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			<ul style="list-style-type: none"> · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint · Update or modify the patient's health care plan to reflect the use of a restraint. <p>B. Behavioral restraint</p> <ol style="list-style-type: none"> 1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger. 2. Indications: Prior to the initiation and/or continuation of a behavioral restraint, the patient must be assessed to identify individual needs to facilitate consideration of less restrictive means. Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of restraint.) 3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate. 4. Discontinuation of restraint: Behavioral restraints will 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.</p> <p>5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint as allowed by their program or job description. The order for restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger.</p> <p>6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application.</p> <p>7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger.</p> <p>8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight hours and b) any reapplication of behavioral restraint within 12 hours after discontinuation.</p> <p>9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral health restraint. Such monitoring will be documented at least every 15 minutes.</p> <p>10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint · Update or modify the patient's health care plan to reflect the use of a restraint 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>C. Chemical restraint</p> <p>1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint.</p> <p>D. Seclusion</p> <p>1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.)</p> <p>2. Seclusion can only be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.</p> <p>3. All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous observation may be accomplished via video and auditory monitoring.</p> <p>E. Reporting deaths related to restraint Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.)</p> <p>References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as		regulations Attachment A: Examples of Alternatives to the Use of Restraints Physical measures Spiritual needs · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines) · Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting · Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns · Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · Use of lap belt in chair as a reminder · Provide glasses, hearing aid, dentures · Tape F/C to ab	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>Based on document review and staff interview, the facility failed to ensure a restraint order was obtained in 1 instance of a physical restraint (patient #26).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #26 (med/surg patient) medical record indicated the following: <ol style="list-style-type: none"> Nurse notes document at 0025 and amended at 0035 on 4/25/14 indicated the patient had been physically held down by two (2) male staff members. There was no order in the medical record for a restraint. Review of facility incident reports indicated an incident report was completed on 4/24/14 at 2248 indicating the following: <ol style="list-style-type: none"> RN #1 responded to a code black (security issue) at "approx 2210" on 4/24/14 and upon arrival to the room of patient #26, RN #2 was attempting to restrain patient #26 "as he was swinging arms and attempting to come out of bed." RN #1 assisted RN #2 in holding the patient's arms and torso to the bed. The document indicated the patient wanted to leave to go home and get 	A000168	<p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A168</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All nursing staff will be educated on the Policy and Procedure titled "Restraint Use-Medical and Behavioral" for the application of any restraint and the required documentation and follow up that is necessary. This includes any use of hands on restraint. Any nurse applying a restraint or initiating seclusion will be responsible to notify the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation has been completed.</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>his/her pain medication.</p> <p>(D) The patient was physically restrained 2 additional times during the code black episode.</p> <p>3. Facility policy titled "Restraint Use-Medical and Behavioral" last reviewed/revised 4/14 stated on page 2: "5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution.....6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint.....without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation."</p> <p>3. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure for Physical or Chemical restraints application at the time the restraint is initiated. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>Read and Sign Date: _____</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Review the Policy: Restraint Use-Medical and Behavioral</p> <p>I have read and understand the Restraint Use-Medical and Behavioral Policy. I understand that the term "restraint" can refer to hands on restraint, such as holding a violent patient down to prevent injury to themselves or others. I acknowledge that a restraint is NEVER to be used as a form of coercion, discipline, convenience, or retaliation by staff and pledge to report any deviation from Policy and Procedure that I witness to my immediate supervisor or to the Quality Director at Ext 568.</p> <p style="text-align: center;">PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1</p> <p>2</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			3	
			4	
			5	
			6	
			7	
			8	
			9	
			10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			11	
			12	
			13	
			14	
			15	
			16	
			SAINT CATHERINE REGIONAL HOSPITAL SUBJECT: Restraint Use-Medical and Behavioral PAGE: 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>DEPARTMENT: Administration-PC</p> <p>-</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14</p> <p>-</p> <p>Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy:</p> <ul style="list-style-type: none"> · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes (Refer to Attachment A for examples of restraint and immobilization not considered restraint.) <p>Policy:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			<ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode <p>Procedure:</p> <ol style="list-style-type: none"> A. Medical restraint <ol style="list-style-type: none"> 1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint). 2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan. 3. Consideration of less 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000171	<p>482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; Based on document review and staff interview, the facility failed to ensure an order for seclusion was time limited in 1</p>	A000171	<p>necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation. 7. Initial in-person physician assessment within 24 hours of initiation: The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation.</p> <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A171 DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p>	07/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>instance (patient #23).</p> <p>Findings include:</p> <p>1. Review of patient #23 medical record indicated the following: (A) An order was written for seclusion at 0057 on 12/10/13 and the patient was placed in seclusion from 12:30 a.m. to 2:45 a.m.. The order was not time limited.</p> <p>2. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All nursing staff will be educated on the Policy and Procedure for the application of any restraint, or initiation of seclusion, and the required documentation and follow up that is necessary including time limiting the duration of seclusion in the MD order. Any nurse applying a restraint will be responsible to notify the House Supervisor. The seclusion room keys have been given to the House Supervisor so no patient can be secluded without the presence of the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation and MD orders has been obtained and completed.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure for the application of Physical or Chemical restraints, as well as, the initiation of seclusion. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: Restraint Use-Medical and Behavioral</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>PAGE: 1 DEPARTMENT: Administration-PC -</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14</p> <p>- Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy: · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes (Refer to Attachment A for examples of restraint and immobilization not considered restraint.) Policy: 1. Seclusion will only be used on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>the BHS unit at this hospital.</p> <p>2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated.</p> <p>3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B).</p> <p>4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint.</p> <p>5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode</p> <p>Procedure:</p> <p>A. Medical restraint</p> <p>1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint).</p> <p>2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation.</p> <p>7. Initial in-person physician assessment within 24 hours of initiation: The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation.</p> <p>8. Ongoing in-person physician assessments and continuation of restraint orders: The treating physician will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated.</p> <p>9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained.</p> <p>10. Patient Monitoring: Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible.</p> <p>11. Documentation: The following will be documented in the medical record whenever medical restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint <p>B. Behavioral restraint</p> <p>1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.</p> <p>2. Consideration of less restrictive means: Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>restraint.)</p> <p>3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.</p> <p>4. Discontinuation of restraint: Behavioral restraints will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.</p> <p>5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint as allowed by their program or job description. The order for restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger.</p> <p>6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application.</p> <p>7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger.</p> <p>8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight hours and b) any reapplication of behavioral restraint within 12 hours after discontinuation.</p> <p>9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral health restraint. Such monitoring will be documented at least every 15 minutes.</p> <p>10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
			<ul style="list-style-type: none"> · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint <p>C. Chemical restraint</p> <p>1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint.</p> <p>D. Seclusion</p> <p>1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.)</p> <p>2. Seclusion can only be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.</p> <p>3. All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous observation may be accomplished via video and auditory monitoring.</p> <p>E. Reporting deaths related to restraint Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR		<p>by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.)</p> <p>References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state regulations</p> <p>Attachment A: Examples of Alternatives to the Use of Restraints</p> <p>Physical measures</p> <p>Spiritual needs</p> <ul style="list-style-type: none"> · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines) · Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting · Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns · Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · Use of lap belt in chair as a reminder 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. Based on document review and staff interview, the facility failed to ensure a patient placed in seclusion was monitored per policy in 1 instance (patient #23).</p> <p>Findings include:</p> <p>1. Review of patient #23 medical record indicated the following: (A) An order was written for seclusion at 0057 on 12/10/13 and the patient was placed in seclusion from 12:30 a.m. to 2:45 a.m.. (B) The medical record lacked evidence that the patient was continuously monitored per policy during the seclusion episode. The record contained evidence of every 15 minute checks.</p> <p>2. Facility policy titled "RESTRAINT & SECLUSION" last reviewed/ revised 12/09 stated on page 7: "Reassessment of the patient in restraint/seclusion for a behavior management reason includes items listed above, as well as monitoring the patient on a continuous basis."</p>	A000175	<p>CMS PLAN OF CORRECTION ID PREFIX TAG: A175 DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint or initiation of seclusion.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All nursing staff will be educated on the Policy and Procedure for the application of any restraint, or initiation of seclusion, and the required documentation and follow up that is necessary. Any nurse applying a restraint will be responsible to notify the House Supervisor. The seclusion room keys have been given to the House Supervisor so no patient can be secluded without the presence of the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation is present in the</p>	07/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
	2. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.		<p>clinical record including continuous monitoring of the secluded patient for the first hour. After the first hour of continuous visual observation by staff, the continuous observation can be accomplished via video and auditory monitoring, per the policy and procedure.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure for the application of Physical or Chemical restraints, as well as, the initiation of seclusion. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: Restraint Use-Medical and Behavioral</p> <p>PAGE: 1 DEPARTMENT: Administration-PC -</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14 -</p> <p>Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
			<ul style="list-style-type: none"> · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes (Refer to Attachment A for examples of restraint and immobilization not considered restraint.) <p>Policy:</p> <ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode <p>Procedure:</p> <p>A. Medical restraint</p> <ol style="list-style-type: none"> 1. Definition: Medical (as 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint).</p> <p>2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation.</p> <p>7. Initial in-person physician assessment within 24 hours of initiation: The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation.</p> <p>8. Ongoing in-person physician assessments and continuation of restraint orders: The treating physician will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated.</p> <p>9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained.</p> <p>10. Patient Monitoring: Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible.</p> <p>11. Documentation: The following will be documented in the medical record whenever medical restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>family (as appropriate) regarding restraint</p> <p>B. Behavioral restraint</p> <p>1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.</p> <p>2. Consideration of less restrictive means: Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.</p> <p>4. Discontinuation of restraint: Behavioral restraints will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.</p> <p>5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>order restraint as allowed by their program or job description. The order for restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger.</p> <p>6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application.</p> <p>7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger.</p> <p>8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight hours and b) any reapplication of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>behavioral restraint within 12 hours after discontinuation.</p> <p>9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral health restraint. Such monitoring will be documented at least every 15 minutes.</p> <p>10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint <p>C. Chemical restraint</p> <p>1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint.</p> <p>D. Seclusion</p> <p>1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.)</p> <p>2. Seclusion can only be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.</p> <p>3. All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous observation may be accomplished via video and auditory monitoring.</p> <p>E. Reporting deaths related</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>to restraint</p> <p>Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.)</p> <p>References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state regulations</p> <p>Attachment A: Examples of Alternatives to the Use of Restraints</p> <p>Physical measures</p> <p>Spiritual needs</p> <ul style="list-style-type: none"> · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines) 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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			
A000178	<p>482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention --</p> <p>o By a--</p> <ul style="list-style-type: none"> - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. <p>Based on document review and staff interview, the facility failed to ensure a 1-hour face-to-face was conducted after implementation of a seclusion order in 1 instance (patient #23).</p> <p>Findings include:</p>	A000178	<ul style="list-style-type: none"> · Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting · Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns · Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · Use of lap belt in chair as a reminder <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A178 DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and</p>	07/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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. Review of patient #23 medical record indicated the following:</p> <p>(A) An order was written for seclusion at 0057 on 12/10/13 and the patient was placed in seclusion from 12:30 a.m. to 2:45 a.m..</p> <p>(B) The medical record lacked evidence that a face-to-face was conducted within 1 hour of the initiation of seclusion.</p> <p>2. Facility policy titled "RESTRAINT & SECLUSION" last reviewed/revised 12/09 indicated the face-to-face is to be performed by a physician within 1 hour.</p> <p>2. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>Procedure for the application of any restraint or initiation of seclusion.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All nursing staff will be educated on the Policy and Procedure for the application of any restraint, or initiation of seclusion, and the required documentation and follow up that is necessary. Any nurse applying a restraint will be responsible to notify the House Supervisor. The seclusion room keys have been given to the House Supervisor so no patient can be secluded without the presence of the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and procedure and to check that proper follow up is conducted, including a face to face with a physician within one hour of initiation of seclusion.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisor will verify proper adherence to the Policy and Procedure for the application of Physical or Chemical restraints, as well as, the initiation of seclusion. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: Restraint Use-Medical and Behavioral</p> <p>PAGE: 1 DEPARTMENT: Administration-PC -</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14</p> <p>- Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy:</p> <ul style="list-style-type: none"> · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes <p>(Refer to Attachment A for examples of restraint and immobilization not considered restraint.)</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>less restrictive means of protecting the patient are not indicated.</p> <p>3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B).</p> <p>4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint.</p> <p>5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode</p> <p>Procedure:</p> <p>A. Medical restraint</p> <p>1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint).</p> <p>2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>requested within 8 hours of its initiation.</p> <p>7. Initial in-person physician assessment within 24 hours of initiation:The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation.</p> <p>8. Ongoing in-person physician assessments and continuation of restraint orders:The treating physician will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated.</p> <p>9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained.</p> <p>10. Patient Monitoring:Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>comfortable as possible.</p> <p>11. Documentation: The following will be documented in the medical record whenever medical restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint <p>B. Behavioral restraint</p> <p>1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.</p> <p>2. Consideration of less restrictive means: Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>the family around the time of its use. Patient and family education will be documented, as appropriate.</p> <p>4. Discontinuation of restraint: Behavioral restraints will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.</p> <p>5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint as allowed by their program or job description. The order for restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger.</p> <p>6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger.</p> <p>8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight hours and b) any reapplication of behavioral restraint within 12 hours after discontinuation.</p> <p>9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral health restraint. Such monitoring will be documented at least every 15 minutes.</p> <p>10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>education with the patient and family (as appropriate) regarding restraint</p> <p>C. Chemical restraint 1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint.</p> <p>D. Seclusion 1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.) 2. Seclusion can only be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.</p> <p>3. All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous observation may be accomplished via video and auditory monitoring.</p> <p>E. Reporting deaths related to restraint Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or		References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state regulations Attachment A: Examples of Alternatives to the Use of Restraints Physical measures Spiritual needs <ul style="list-style-type: none"> · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines) · Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting · Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns · Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · Use of lap belt in chair as a reminder 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>seclusion-</p> <p>(i) Before performing any of the actions specified in this paragraph;</p> <p>(ii) As part of orientation; and</p> <p>(iii) Subsequently on a periodic basis consistent with hospital policy.</p> <p>Based on document review and staff interview, the facility failed to ensure staff were trained in the application of restraints for 2 of 2 Registered Nurses (RN #1 and RN #2) involved in a restraint episode for 1 patient (patient #26).</p> <p>Findings include:</p> <p>1. Review of patient #26 (med/surg patient) medical record indicated the following: (A) Nurse notes document at 0025 and amended at 0035 on 4/25/14 indicated the patient had been physically held down by two (2) male staff members.</p> <p>2. Review of facility incident reports indicated an incident report was completed on 4/24/14 at 2248 indicating the following: (A) A code black (security issue) was called and RN #1 assisted RN #2 in holding the arms and torso of patient #26 to the bed. (B) The patient was physically restrained 2 additional times during the code black episode.</p>	A000196	<p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.13-Patient Rights</p> <p>ID PREFIX TAG: A196</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/17/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: All employees, clinical and non clinical, who may be involved with the application of a restraint, or the care of a patient in restraints will have Restraint Education and BLS/First Aid training with appropriate documentation in their Education file.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All employee education files will be audited and individuals determined to be potentially involved with the application of a patient restraint or the care of a patient in restraints will be provided the appropriate training and education in the use of these restraints and the care the of the patients in restraints. This training and education will include</p>	07/17/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>3. Facility policy titled "Restraint Use-Medical and Behavioral" last reviewed/revised 4/14 stated on page 7: "A. In order to minimize the use of restraint, all direct care staff as well as any other staff involved in the use of restraint receive ongoing training....."</p> <p>4. Personnel files for RN #1 and RN #2 lacked evidence of training in the use of restraints.</p> <p>5. Staff member #AA1, Director of Medical Records, verified at 2:00 p.m. on 6/5/14 that the personnel files for RN #1 and RN #2 lacked evidence of training in the use of restraints.</p>		<p>BLS and/or First Aid training. Restraint education and BLS/First Aid education will be added to the new employee orientation checklist and the annual employee competencies. The documentation for this training will be maintained in the employee education file.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and Nursing Education; Beth Fisher RN, Unit Director; Kelli Braswell RN, ED Director, Doug Lee, Human Resources</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: All current nursing staff will be trained on Restraint use and documentation. All current employees will be provided Basic First Aid training. All employees hired after 7/17/2014 will be provided education on the facility Restraint Policy and Basic First Aid. If appropriate for the employee's position, BLS certification training will be offered and provided without cost to the employee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Basic First Aid/BLS and Restraint training will be included in the Annual employee competencies.</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: Restraint Use-Medical and Behavioral</p> <p>PAGE: 1 DEPARTMENT: Administration-PC -</p> <p>EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14 -</p> <p>Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital.</p> <p>Scope: The following are not considered restraint under this policy: · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>post-procedure care processes</p> <ul style="list-style-type: none"> · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes <p>(Refer to Attachment A for examples of restraint and immobilization not considered restraint.)</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode <p>Procedure:</p> <p>A. Medical restraint</p> <ol style="list-style-type: none"> 1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint).</p> <p>2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan.</p> <p>3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p> <p>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order.</p> <p>6. Initiation without orders:If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation.</p> <p>7. Initial in-person physician assessment within 24 hours of initiation:The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation.</p> <p>8. Ongoing in-person physician assessments and continuation of restraint orders:The treating physician will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained.</p> <p>10. Patient Monitoring: Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible.</p> <p>11. Documentation: The following will be documented in the medical record whenever medical restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint · Update or modify the patient's health care plan to reflect the use of a restraint. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>B. Behavioral restraint</p> <p>1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger.</p> <p>2. Indications: Prior to the initiation and/or continuation of a behavioral restraint, the patient must be assessed to identify individual needs to facilitate consideration of less restrictive means. Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of restraint.)</p> <p>3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.</p> <p>4. Discontinuation of restraint: Behavioral restraints will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan.</p> <p>5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>program ("residents") may also order restraint as allowed by their program or job description. The order for restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger.</p> <p>6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application.</p> <p>7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger.</p> <p>8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>hours and b) any reapplication of behavioral restraint within 12 hours after discontinuation.</p> <p>9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral health restraint. Such monitoring will be documented at least every 15 minutes.</p> <p>10. Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied:</p> <ul style="list-style-type: none"> · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint · Update or modify the patient's health care plan to reflect the use of a restraint <p>C. Chemical restraint</p> <p>1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint.</p> <p>D. Seclusion</p> <p>1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.)</p> <p>2. Seclusion can only be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.</p> <p>3. All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>observation may be accomplished via video and auditory monitoring.</p> <p>E. Reporting deaths related to restraint Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.)</p> <p>References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state regulations</p> <p>Attachment A: Examples of Alternatives to the Use of Restraints</p> <p>Physical measures Spiritual needs</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000206	<p>482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:]</p> <p>(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</p> <p>Based on document review and staff interview, the facility failed to ensure that unlicensed direct care staff who may restrain patients had training in first aid techniques and certification in the use of cardiopulmonary resuscitation for 2 of 2 Behavioral Health Certified Nursing Assistants (CNA) (Staff # N19 & N21)</p>	A000206	<ul style="list-style-type: none"> · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines) · Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting · Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns · Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · <p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A206</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/17/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: All employees,</p>	07/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>involved in a restraint episode.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of staff #19 & 21's personnel files lacked documentation of training in first aid techniques and certification in the use of cardiopulmonary resuscitation. Staff #19 & 21's personnel files indicated each worked on the inpatient Behavioral Health unit. 2. On 06-04-14 at 1520 hours, staff #44, manager of Behavioral Health inpatient unit, confirmed the staff may use lap belts as restraints and 4 way soft restraints. 3. On 06-05-14 at 1150 hours, staff #41 confirmed that staff #19 & 21's personnel file lacked documentation of training in first aid techniques and certification in the use of cardiopulmonary resuscitation. 		<p>clinical and non clinical, who may be involved with the application of a restraint, or the care of a patient in restraints will have Restraint Education and BLS/First Aid training in their Education file.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All employee education files will be audited and individuals determined to be potentially involved with the application of a patient restraint or the care of a patient in restraints will be provided the appropriate training and education in the use of these restraints and the care the of the patients in restraints. This training and education will include BLS and/or First Aid training. The documentation for this training will be maintained in the employee education file.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and Nursing Education; Beth Fisher RN, Unit Director; Kelli Braswell RN, ED Director, Doug Lee, Human Resources</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000263	<p>482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p> <p>The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>Based on document review and staff interview, it was determined that the hospital failed to track medical errors and adverse patient (reportable) events (see A 0286) and failed to ensure that the Quality Assessment/Performance</p>	A000263	<p>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED: All employees hired after 7/17/2014 will be provided education on the facility Restraint Policy and basic first aid. If appropriate for the employees position, BLS certification training will be offered and provided without cost to the employee.</p> <p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.21-Quality Assessment and Performance Improvement Program</p> <p>ID PREFIX TAG: A263</p>	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Improvement program included all hospital departments and services, including those services furnished under contract or arrangement (see A 0308).</p> <p>The cumulative effect of these systemic problems resulted in the hospital's inability to ensure maintenance and demonstrated evidence of a Quality Assessment and Performance Improvement program.</p>		<p>DATE DEFICIENCY WILL BE CORRECTED: 7/3/14</p> <p>WHAT IS THE PLAN OF CORRECTION: All hospital departments and services, both in-house and contracted, will be represented in the Saint Catherine Regional Hospital QAPI Program.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Each department and service within Saint Catherine Hospital will be contacted by the Quality Director on 7/3/14. It will be determined at that time what indicator will or has been monitored monthly within that service or department. A QAPI plan will be established and/or documented, at that time, and placed in the Quality Council Minutes binder to be reviewed at the next Quality Council Meeting.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and Nursing Education; Beth Fisher RN, Unit Director; Kelli Braswell RN, ED Director, Clark Daniels, Lab Director; Lisa Maddox, Radiology Director; Dave Millet, Facilities Director; Carol Blankenbaker, Medical Records</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: Each QAPI plan will be presented and tracked in the monthly Quality Council Meeting. The Quality Council Meeting Minutes template and Quality Council Agenda, used to document the contents of each meeting will be updated to include each department and the QAPI plan they are tracking.</p> <p>MEETING MINUTES DATE Time: Location: Members Present: Members Absent: AGENDA ITEM</p> <p>APPROVAL OF MINUTES MONTH APPROVED</p> <p>FIRST:</p> <p>SECOND: OLD BUSINESS REPSONSIBLE PARTY</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>RADIOLOGY</p> <ol style="list-style-type: none"> 1. Radiology 2. Tele-radiology 3. Ultrasound 4. CT Scanner 5. Mammography 6. MRI <ul style="list-style-type: none"> · In-house · Contracted 7. Nuclear Medicine <p>LABORATORY</p> <ol style="list-style-type: none"> 1. In-house 2. Ref Lab 3. Blood bank 4. Respiratory Care 5. Sleep lab <p>FACILITIES</p> <ol style="list-style-type: none"> 1. Bioengineering-Contracted 2. Biohazard Waste Hauler 3. Central Sterile 4. Dietetic service <ol style="list-style-type: none"> 1. In-house 2. Contracted 5. Housekeeping 6. Linen Services 7. Maintenance 8. Security <p>MEDICAL RECORDS</p> <ol style="list-style-type: none"> 1. Transcription 2. Delinquencies <p>NURSING</p> <ol style="list-style-type: none"> 1. Geriatric Psych 2. DC Planning/SS 3. Utilization Review 4. BHS Laundry 5. Chart audits 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>ER DEPARTMENT</p> <ol style="list-style-type: none"> 1.PICC Services 2.Physical Therapy 3.Response to Patient Emergency 4.Speech Pathology 5.ER Dept 6.Infusion Therapy <p>PHARMACY</p> <ol style="list-style-type: none"> 1.Medication Errors <p>QUALITY/RISK MGT</p> <ol style="list-style-type: none"> 1.Event reports 2.Reportable Events 3.Medical Errors <p>INFECTION PREVENTION</p> <p>LISA M.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			CLARK D.	
			DAVE M.	
			CAROL B.	
			BETH F.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			KELLI B.	
			BILL P.	
			CHRISSY P.	
			CHRISSYP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000286	<p>482.21(a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.</p> <p>Based on document review and interview, the facility failed to track medical errors and adverse patient (reportable) events as part of its Quality Assessment/Performance Improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not track medical errors</p>	A000286	<p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A286</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Any event which is out of the ordinary and has the potential for or actual injury to a patient, visitor, or employee; or occupational illness; or</p>	07/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
	and adverse patient (reportable) events. 2. In interview, on 6-5-14 at 10:30 am, employee #A9, Quality Assurance Leader, confirmed the above and no other documentation was provided prior to exit.		<p>damage to hospital or patient property will be reported in a timely manner and documented according to facility Policy and Procedure. The Quality Assessment and Performance Improvement program will track Medical Errors and Adverse patient (Reportable) events in the monthly Quality Council meeting.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Staff will be educated on the policy for Event reporting which includes the definition of a reportable event. These event reports are accessed, printed, and reviewed daily by the Quality Director. Medical Errors and Adverse patient (Reportable) events are currently being monitored and tracked at Saint Catherine Regional Hospital; however, they are not being reported to the Quality Council. This has been added to the Quality Council Meeting Minutes template and will be reviewed and/or discussed monthly in the Quality Council meeting.</p> <p>WHO IS RESPONSIBLE: Kimmie C. Perra RN, Quality Director; Kelli Braswell RN, ED Director;</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The QA/PI plan for medical Errors and Adverse Patient events will be presented and tracked in the monthly Quality Council Meeting. The Quality Council Meeting Minutes template and Quality Council Agenda, used to document the contents of each meeting will be updated to include the QAPI plan.</p> <p>Read and Sign Date: _____</p> <p>Review the Policy: Event reporting</p> <p>I have read and understand this policy. I understand that I must report ANY event which is out of the ordinary and has or can cause injury to patients, visitors or employees. This includes, but is not limited to: patient to patient altercations, medication errors, AMA's or any other situation, not just falls.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			PRINT NAME SIGNATURE / TITLE DEPARTMENT	
			1	
			2	
			3	
			4	
			5	
			6	
			7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			8	
			9	
			10	
			11	
			12	
			13	
			14	
			15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>16</p> <p>SAINT CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: EVENT REPORTING</p> <p>PAGE: 1 OF : 5 DEPARTMENT: NURSING</p> <p>EFFECTIVE 8/98 APPROVED BY: CNO / QUALITY MANAGER</p> <p>REVISED: 3/95, 9/97, 8/00, 5/03, 11/05, 8/07, 10/10 REVIEWED: 10/07,6/13</p> <p>POLICY: It is the policy of the hospital that all employees have the responsibility to report any Event which is out of the ordinary and has a potential for or actual injury to a patient, visitor, or employee; occupational illness; or damage to hospital or patient property. All employees have an affirmative duty to report any Event, which is not consistent with the routine operation of the Hospital and its staff or the routine care of a particular patient, visitor, or physician, or any situation, which has potential to cause injury to a patient, visitor, or employee. This duty applies to "near miss" situations. Willful failure to report such Events may subject the employee to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>disciplinary action up to and including termination. In no case should the Event report be filed with the medical record. The report is a factual description of the Event and should be completed in an objective manner. The Event report is a confidential document and is not to be photocopied or shared with individuals who are not required to see it. Determination as to the liability of Saint Catherine Regional Hospital or any injury case is the responsibility and the right of our insurance company after a thorough investigation of the facts involved. (Employees are not to admit or discuss hospital liability with visitors, outpatients, or members of their families.) Should they inquire or insist on discussing hospital liability, they are to be referred to Administration. Such consultations are available only during hours when the Administrative Offices are normally staffed.</p> <p>DEFINITION: An Event is an incidence/occurrence which is out of the ordinary and has a potential for or actual injury to a patient, visitor, or employee; occupational illness; or damage to hospital or patient property. This also includes unanticipated outcomes/adverse events and medication errors.</p> <p>PROCEDURE: Event Reports must be put into the computer. 1. The person who discovers an Event is responsible for initiating the Event Report Form</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>immediately or as soon as possible.</p> <p>When possible, the individual involved or responding to the Event should initiate the report. 2. No employee or staff members will be subject to disciplinary action for reporting non intentional or non-malicious Events. Staff members will be subject to disciplinary action and/or employment termination for failure to report known Events. .</p> <p>3. Investigation into an event must begin within 24 hours of the event. On weekends and holidays all event reports should be routed to the House Supervisor to review report and initiate action plan. 4. The Risk Manager, in accordance with established department criteria and individual fact situations, shall investigate and preserve for reference and use, the information obtained from medical record review, witness interviews, defective equipment/supplies, and any other applicable potential evidentiary data. 5. All Events considered by the risk manager to be potentially compensable will be reported to applicable casualty insurance companies.</p> <p>6. Event reports will be reviewed monthly at the Quality Council meeting with reporting to MEC and Governing Board for review and recommendations.</p> <p>APPENDIX A: MEDICATION EVENT TERMINOLOGY A Medication Occurrence is defined</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>as any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional or patient, including both error and unanticipated adverse outcomes. (NCCMERP, ASCP)</p> <p><u>PRESCRIBING</u></p> <p>v Medication Occurrences related to prescribing may result from: vOrders from a drug to which the patient has a known allergic reaction, vPrescribing the wrong drug for the particular condition or indication, vPrescribing drugs which are contraindicated due to other patient factors including disease states, clinical conditions, prescribing duplicate therapy, vOrdering the incorrect rate or frequency of administration, vPrescribing the wrong route of administration, vAn incorrect dose or concentration is specified, vAn incorrect dose form is ordered, vPrescribing a drug which may interact with other drug therapy, vGiving the wrong instructions (i.e., sig), vWriting in a manner, which is illegible to other healthcare providers.</p> <p><u>OMISSION</u></p> <p>Any drug, which is not given (with the exception of patient refusal of therapy) before the next scheduled dose is considered omitted. Occurrences may be the result of failure to send the order to pharmacy, failure to dispense the drug, failure to transcribe the drug on the MAR,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>absence of the patient from the unit, failure to document, system Occurrences resulting in the absence of the transcription on the MAR, or failure to order a needed dose of medication.</p> <p><u>TIMING</u> Timing errors include changes from physician-ordered schedule, dispensing errors resulting in delay of therapy, or administration errors, which result in a patient's receiving a dose greater than one-hour +1- from the original schedule. Some Occurrences may be due to blood products, which cannot be interrupted, or other clinical circumstances beyond provider control. Giving a drug when not ordered as well as not giving a drug at the time due may be timing Occurrences. Transcription Occurrences frequently result in this type of Occurrence.</p> <p><u>DOSAGE/ROUTE FORM</u> These Occurrences include incorrect route of administration from what was ordered or dispensed, or from Occurrences (capsule versus injection vs. suppository, etc.) Occurrences may also be related to crushing a sustained-release preparation, which would result in altered drug availability, or in technique of administration (i.e., deep IM vs. z-track, which could allow abscess formation)</p> <p><u>IMPROPER DOSE</u> Medication Occurrences may be the result of a dose over or under the prescribed or appropriate dosed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>based on patient clinical factors, including age, renal and hepatic metabolic factors, diagnosis, etc. Inadvertent duplications in dose, calculation Occurrences, incorrect rate of administration, or failure to consider pertinent clinical data are part of this Occurrence type.</p> <p><u>UNAUTHORIZED DRUG</u> Medication Occurrences relating to unauthorized drug use includes giving a drug to the wrong patient, failure to record a needed dose of medication, administration of a drug without a valid prescription, incorrect transcription and administration of an incorrect drug or dose, administration of a drug when the drug was ordered to be held, or incorrect administration from a protocol.</p> <p><u>DRUG PREPARATION</u> Occurrences related to preparation/compounding or dispensing include incorrect admixtures of parenteral or enteral products, contamination of a product, alteration of a drug, misbranding of a drug, failure to store the drug according to manufacture labeling requirement, or failure to activate a drug to allow receipt of the prescribed dose (i.e., piggyback or inhaler inactivated dose due).</p> <p><u>ADMINISTRATION</u> Occurrences in administration include the incorrect or inappropriate procedures, technique, equipment malfunctions or unavailability to assure safe administration. Controlled substance waste not</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>recorded or witnessed is also included here. Occurrences in documentation are also types of administration Occurrence.</p> <p><u>DETERIORIATED DRUG</u></p> <p>Occurrences of this type include dispensing or administration of expired or physically compromised drugs, precipitations, cloudy or hazy appearances, or incompatible drug co-administration.</p> <p><u>MONITORING</u></p> <p>Monitoring Occurrences include failure to review the prescribed drug regimen for potential or actual complications, or failure to reference pertinent laboratory or other clinical data essential to accurate drug administration, or failure to correlate therapy with patient response. Infiltration or extravasations during parenteral therapy is indicated here.</p> <p><u>DISPENSING</u></p> <p>Occurrences of dispensing include dispensing the prescribed drug to the wrong patient, dispensing the wrong drug, wrong dose, dispensing a drug contraindicated by allergies or clinical condition/indication, or dispensing a medication from home improperly identified by the pharmacist or practitioner.</p> <p><u>COMPLIANCE/OTHER</u></p> <p>Occurrences in medication use may also be due to patient factors, such as the refusal of a critical medication, failure to swallow, pocketing, or other patient behavior. The patient has a right to refuse medication at any time. (Refer to Patient Rights Policy) Any other Occurrence, which</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000308	<p>482.21 QAPI GOVERNING BODY, STANDARD TAG ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. Based on document review and interview, the hospital's governing body failed to ensure that the Quality Assessment/Performance Improvement (QAPI) program included all hospital departments and services, including those</p>	A000308	<p>does not fall into an above category, may be documented here. <u>CONTROLLED SUBSTANCE</u> Occurrences of Class I-V controlled substances, which do not fall in any above category, including loss/theft or other diversion or lost keys/password discrepancies. <u>ADVERSE DRUG REACTION</u> Significant adverse drug reactions/medication occurrences are those events, which are; (1) unintended; (2) undesirable; (3) unexpected effects of prescribed medication which result in (1) discontinuing or modifying a medication <u>WITH</u> (2) initial or (3) prolonged hospitalization which includes (4) treatment with a prescription drug <u>AND</u> (5) result in (a) disability; (b)</p> <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A308 DATE DEFICIENCY WILL BE CORRECTED: 7/3/14</p>	07/03/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>services furnished under contract or arrangement for 6 (discharge planning, infusion therapy, medical records, physical therapy, respiratory care, and sleep lab) directly-provided services and 8 (blood bank, dietician, reference laboratory, medical records, magnetic resonance imaging, teleradiology, speech pathology, and transcription) contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the hospital's QAPI program indicated it did not include the directly-provided services of discharge planning, infusion therapy, medical records, physical therapy, respiratory care, and sleep lab. 2. Review of the hospital's QAPI program indicated it did not include the contracted services of blood bank, dietician, reference laboratory, medical records, magnetic resonance imaging, teleradiology, speech pathology, and transcription. 3. In interview, on 6-5-14 at 10:30 am, employee #A9, Quality Assurance Leader, confirmed the above and no other documentation was provided prior to exit. 		<p>WHAT IS THE PLAN OF CORRECTION: All hospital departments and services, both in-house and contracted, will be represented in the Saint Catherine Regional Hospital QAPI Program.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Each department and service within Saint Catherine Hospital will be contacted by the Quality Director on 7/3/14. It will be determined at that time what indicator will or has been monitored monthly within that service or department. A QAPI plan will be established and/or documented, at that time, and placed in the Quality Council Minutes binder to be reviewed at the next Quality Council Meeting.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and Nursing Education; Beth Fisher RN, Unit Director; Kelli Braswell RN, ED Director, Clark Daniels, Lab Director; Lisa Maddox, Radiology Director; Dave Millet, Facilities Director; Carol Blankenbaker, Medical Records</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: Each QAPI plan will be presented and tracked in the monthly Quality Council Meeting. The Quality Council Meeting Minutes template and Quality Council Agenda, used to document the contents of each meeting will be updated to include each department and the QAPI plan they are tracking.</p> <p>MEETING MINUTES DATE Time:</p> <p>Location: Members Present: Members Absent: AGENDA ITEM</p> <p>APPROVAL OF MINUTES MONTH APPROVED</p> <p>FIRST:</p> <p>SECOND: OLD BUSINESS DISCUSSION/FINDINGS CONCLUSIONS/RECOMMENDATIONS RESPONSIBLE PARTY</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>STANDING ITEMS DISCUSSION/FINDINGS CONCLUSIONS/RECOMMENDATIONS RESPONSIBLE PARTY QUALITY REPORTS: RADIOLOGY 1. Radiology 2. Tele-radiology 3. Ultrasound</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			4.CT Scanner 5.Mammography 6.MRI · In-house · Contracted 7. Nuclear Medicine LABORATORY 1.In-house 2.Ref Lab 3.Blood bank 4.Respiratory Care 5.Sleep lab FACILITIES 1.Bioengineering-Contracted 2.Biohazard Waste Hauler 3.Central Sterile 4.Dietetic service 1.In-house 2.Contractd 5.Housekeeping 6.Linen Services 7.Maintenance 8.Security MEDICAL RECORDS 1.Transcription 2.Delinquencies NURSING 1.Geriatric Psych 2.DC Planning/SS 3.Utilization Review 4.BHS Laundry 5.Chart audits ER DEPARTMENT 1.PICC Services 2.Physical Therapy 3.Response to Patient Emergency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000395	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review, a registered nurse failed to adequately supervise the care provided for 1 of 5 patients with orders for pain medication (patient #26).</p> <p>Findings include:</p> <p>1. Patient #26 was physically restrained on 4/24/14 because he/she was attempting to leave the hospital to go home and get his/her pain medication. It could not be determined that an RN supervised the care and assessed the patients need for the medication prior to physically restraining the patient.</p>	A000395	<p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.23-RN Supervision of Nursing Care</p> <p>ID PREFIX TAG: A395</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7/10/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Nursing staff will follow Saint Catherine Regional Hospital Policy and Procedure for the application of any restraint.</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>2. Review of patient #26 medical record indicated the following:</p> <p>(A) The patient presented to the hospital via ambulance at 1300 on 4/24/14 with complaint of chest pain.</p> <p>(B) A list containing medications taken at home included, but was not limited to, Dilaudid 4 mg (pain medication) three (3) times a day and Neurontin 300 mg (anti-convulsant used at times for pain) 3 times a day.</p> <p>(C) An order was written at 1608 on 4/24/14 for Dilaudid 4 mg prn (as needed) and Neurontin 300 mg tid (three times a day).</p> <p>(D) The medical record lacked evidence that the patient was assessed for pain prior to the patient becoming upset at 2230 on 4/24/14 and leaving the facility.</p> <p>(E) The medical record indicated the patient was physically held down by two (2) male staff members beginning at 2230 on 4/24/14 and prior to leaving the facility.</p> <p>3. Review of facility incident reports indicated an incident report was completed on 4/24/14 at 2248 indicating the following:</p> <p>(A) RN #1 responded to a code black (security issue) at "approx 2210" on 4/24/14 and upon arrival to the room of patient #26, RN #2 was attempting to</p>		<p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>The Policy and Procedure for the application of Restraints on a patient will be reviewed and updated if necessary to ensure that patient needs are assessed and less restrictive measures are attempted prior to the application of any restraint. All nursing staff will be educated on the Policy and Procedure for the application of any restraint including the need for patient assessment of needs and less restrictive measures to be attempted prior to application and the required documentation and follow up that is necessary after application of a restraint. Any nurse applying a restraint or initiating seclusion will be responsible to notify the House Supervisor. The House Supervisor will be responsible to ensure adherence to the policy and check that proper documentation has been completed.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Beth Fisher, RN Unit Director</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 6/20/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>restrain patient #26 "as he was swinging arms and attempting to come out of bed." (B) RN #1 assisted RN #2 in holding the patients arms and torso to the bed. (C) The document indicated the patient wanted to leave to go home and get his/her pain medication. (D) The patient was physically restrained 2 additional times during the code black episode and prior to the patient leaving the facility.</p> <p>4. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>		<p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The House Supervisor will verify proper adherence to the Policy and Procedure for Physical or Chemical restraints, including patient assessment for identification of less restrictive measures attempted and failed prior to application of the restraint. The House Supervisor will also check that the proper documentation is completed in the patient's medical record. The House supervisor will be responsible to notify the Unit Director and fill out an event report. The Quality Director will, upon receipt of the event report, also verify that the Policy and Procedure was followed and that all necessary documentation is present in the clinical record.</p> <p>Read and Sign Date: _____ Review the Policy: Restraint Use-Medical and Behavioral I have read and understand the Restraint Use-Medical and Behavioral Policy. I understand that it is the nurse's responsibility to notify the House Supervisor if he/she is utilizing a restraint, either chemical or physical, regardless if it is Medical or behavioral in nature. I</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>understand that it is the House Supervisor's responsibility to verify proper adherence to the Policy and Procedure and to check that the proper documentation is done, notify the Unit Director, and ensure the MD order is complete and includes a time limitation. I also understand that I am NOT to participate in the application of or care of a restrained patient if I do not have documentation of current BLS or First Aid training. I acknowledge that a restraint is NEVER to be used as a form of coercion, discipline, convenience, or retaliation by staff and pledge to report any deviation from Policy and Procedure that I witness to my immediate supervisor or to the Quality Director at Ext 568.</p> <p>PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>16 SAINT CATHERINE REGIONAL HOSPITAL SUBJECT: Restraint Use-Medical and Behavioral PAGE: 1 DEPARTMENT: Administration-PC EFFECTIVE: 9/04 APPROVED BY: CNO, Director of Quality Management, Chief of Staff REVISED: 10/06, 4/14 Purpose: This policy and procedure is established to guide the application of medical and behavioral restraints in all settings within Saint Catherine Regional Hospital. Scope: The following are not considered restraint under this policy: · Standard health care practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, and the related post-procedure care processes · Adaptive support in response to assessed patient need · Forensic or correctional restrictions used for security purposes (Refer to Attachment A for examples of restraint and immobilization not considered restraint.) Policy: 1. Seclusion will only be used on the BHS unit at this hospital. 2. Physical restraint may be used according to this policy when warranted by the patient's condition and therapy, and when less restrictive means of protecting the patient are not indicated. 3. All staff assigned to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>apply or monitor restraint will demonstrate corresponding competence (Attachment B). 4. Staff will ensure that patients are treated with dignity and privacy, including during periods of restraint. 5. Debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode</p> <p>Procedure: A. Medical restraint</p> <p>1. Definition: Medical (as opposed to behavioral health) restraint means restricting a patient's movement to assist with the provision of medical or surgical care. Patient immobilization that is a normal component of a procedure (e.g. MRI, surgery, etc.) is not considered restraint. (Refer to Attachment A for examples of medical restraint). 2. Indications: Prior to the initiation and continuation of medical restraint, the patient must be assessed to require restraint to prevent interference with his or her treatment plan. 3. Consideration of less restrictive means: Prior to the initiation and continuation of restraint, alternate means of protecting the patient will be considered. (Attachment A gives examples of alternatives to the use of restraint.) 4. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient/family education will be documented.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>5. Orders: Restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint. The order for restraint will include the type of and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. PRN restraint orders will be neither issued nor accepted. If a patient has been removed from restraints, and the patient begins exhibiting the same behavior, the registered nurse may reapply the restraint, but must obtain a new order. 6. Initiation without orders: If a physician is not available, a registered nurse may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the patient's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 8 hours of its initiation. 7. Initial in-person physician assessment within 24 hours of initiation: The treating physician will perform an in-person assessment of the restrained patient within 24 hours of initiation to verify that restraint is indicated and that less</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>restrictive means are not appropriate. The physician will reorder or discontinue restraint at the time of that evaluation. 8. Ongoing in-person physician assessments and continuation of restraint orders: The treating physician will perform in-person assessments of a restrained patient at least once every calendar day, at which time restraint will be either reordered or discontinued as indicated. 9. Early discontinuation of restraint: Restraint will be discontinued as soon as it is no longer indicated by the patient's actions or the nature of the patient's treatment plan. Restraint may be reapplied, but a new order is obtained. 10. Patient Monitoring: Patients in restraint will be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Patients will be observed at least every two hours to assure that restraint remains indicated, that restraining devices remain safely applied, and that the patient remains as comfortable as possible. 11. Documentation: The following will be documented in the medical record whenever medical restraint is applied: · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>· Discussions and education with the patient and family (as appropriate) regarding restraint</p> <p>B. Behavioral restraint 1. Definition: Behavioral restraint is the restriction of patient movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the patient or others in imminent danger. 2. Consideration of less restrictive means: Prior to the initiation and continuation of a behavioral restraint, alternate means of protecting the patient and others will be considered. (Attachment A gives examples of alternatives to the use of restraint.) 3. Conversation with patient and family: To the extent practical, the issue of restraint will be discussed with the patient and the family around the time of its use. Patient and family education will be documented, as appropriate.</p> <p>4. Discontinuation of restraint: Behavioral restraints will be discontinued as soon as it is no longer indicated by the patient's behavior or the nature of the patient's treatment plan. 5. Orders: Behavioral restraints will be initiated or continued upon the order of a treating physician with current privileges at this institution. Treating physicians in a post-graduate medical education program ("residents") may also order restraint as allowed by their program or job description. The order for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>restraint will include the type of restraint to be applied and will be based on specific behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. Behavioral health restraint may not be ordered for longer than four hours for adult patients, two hours for children between nine and 17 years old, and one hour for children eight years old or younger. 6. Initiation without orders: A registered nurse may initiate behavioral restraint in an emergency in advance of a physician's order. In such cases, a treating physician will perform a face-to-face assessment of the patient within one hour of its application. 7. Renewal of restraint orders: Before the expiration of the original order, a treating physician may reorder the behavioral health restraint based on the assessment of the registered nurse. However, the physician must perform an in-person assessment for at least every eight hours for adults and at least every four hours for patients 17 years old or younger. 8. Notification of the nurse manager: The nursing manager on duty will be notified of a) any behavioral restraint that continues to be applied for more than eight hours and b) any reapplication of behavioral restraint within 12 hours after discontinuation. 9. Patient monitoring: Appropriately trained staff will continuously observe patients in behavioral</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>health restraint. Such monitoring will be documented at least every 15 minutes. 10.</p> <p>Documentation: The following will be documented in the medical record whenever a behavioral restraint is applied: · The patient's actions or condition that indicated the initial and continued use of restraint · The less restrictive alternative(s) to restraint considered · Restraint orders · Patient monitoring · Significant changes in the patient's condition · Discussions and education with the patient and family (as appropriate) regarding restraint</p> <p>C. Chemical restraint 1. Definition: A chemical restraint is a medication used to sedate patients or restrict their freedom of movement that is not a standard part of the treatment for their medical or psychiatric condition. On the rare occasion that chemical restraint is used in the acute setting, it accompanies the initiation of physical behavioral health restraint. The protections afforded patients for this physical restraint (Section B above) also ensures patients' rights for chemical restraint. D. Seclusion 1. Definition: Seclusion is defined as the involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving. (Infection control practices of isolation are excluded.) 2. Seclusion can only</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>be used in emergency situations if needed to ensure the patient's safety and less restrictive interventions have been shown to be ineffective. Documentation in the patient's medical record should indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the use of more restrictive measures. An emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents immediate and serious danger to the safety of the patient, other patients, staff or others.³ All procedures outlined for a behavioral restraint (Section B Above) will be followed for seclusion. However, after the first hour of continuous visual observation by staff, the continuous observation may be accomplished via video and auditory monitoring. E. Reporting deaths related to restraint Staff will promptly notify Saint Catherine Regional Hospital management of the death of any patient during or within 24 hours of the end of an episode of restraint. Management, in consultation with the Department of Quality, Member and Regulatory Services, will notify the Department of Health Services—on behalf of the Centers for Medicare & Medicaid</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Services (CMS)—of any patient who dies during or within 24 hours of the end of an episode of behavioral health restraint. The reporting of deaths related to medical restraint will be governed by Saint Catherine Regional Hospital's policy on reporting to external agencies. (Attachment F gives an example of a restraint decision tree.) References: CMS, Joint Commission on Accreditation of Healthcare Organizations, state regulations</p> <p>Attachment A: Examples of Alternatives to the Use of Restraints</p> <p>Physical measures</p> <p>Spiritual needs</p> <ul style="list-style-type: none"> · Exercise and activities (arts, crafts, hobbies, coloring books, crossword puzzles, videos, books, and magazines)· Contact patient's pastor, minister, priest, or rabbi · Anticipate and provide for basic needs of hunger (snacks), thirst, and toileting· Offer sacraments of Communion, Reconciliation, and Anointing of the Sick · Promote normal sleep patterns· Use sitter or volunteer to read to patient · Relaxation techniques · Use audio tapes · Use of lap belt in chair as a reminder · Provide glasses, hearing aid, 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>dentures</p> <ul style="list-style-type: none"> · Tape F/C to abdomen of male patient <p>Psychological measures</p> <p>Environmental measures</p> <ul style="list-style-type: none"> · Explain all procedures, be aware of fear of the unknown· 1:1 communication to inform patient of safety precautions and orient to environment · Orient patient to reality often· Use of cushions/pads to maintain safety (mattress on the floor) · Provide for companionship: Family, friends, church members, volunteers, sitters· Locate patient next/close to nurse's station · Holding/cuddling infants and young children· Use appropriate lighting—night light, increase or decrease light in room depending on patient's eyesight or medical condition · Use TV, radio, or music as diversion· Use of Geri chair · Allow patient to wear street clothes, underwear, or shoes· Use bed alarms, door alarms <p>Physiological measures</p> <ul style="list-style-type: none"> · Decrease or control noise level · Review medications for side effects & interactions· Call light within reach 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			<ul style="list-style-type: none"> · Review chart for abnormal lab results· Floor or room uncluttered · Collaborate with other healthcare team members & evaluate treatment plan· Urinal or bedpan within reach · Initiate frequent bathroom rounds· Position commode, walker, cane, or prosthetic devices near bedside · Provide adequate pain medication· Position tubes/drains out of sight · Eliminate itch (if scratching)· Control activity level (visitors, coordinate activities/treatments) · Schedule family/friends to stay with patient <p style="text-align: right;">Patient actions to be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>considered in the application of restraints</p> <p>Action Example of device Type of restraint Patient severely combative or violent due to mental state Two point soft restraints Four-point soft restraints Behavioral restraint Restricting movement of confused patient from removing medical device (IV, endotracheal tube, catheter, drains, etc.) Soft wrist restraints Mittens Medical restraint Confused patient attempting to climb out of bed Bed rails x2 Not restraint if can put rail down themselves Post-op patient needs to lay on his/her side without rolling out of bed Bed rails Not restraint if can put rail down Patient sliding out of chair Lap belt Not restraint if patient can undo themselves Patient immobilized during MRI, circumcision, operative procedure Soft wrist restraints Safety belt Not restraint Protection patient from falling out of bed, using side rails Bed rails Not restraint if patient can put rail down themselves Patient transported via gurney or wheelchair Safety belt Not restraint Patient with head injury, at risk for falls Helmet Not restraint Patient under arrest, being</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>guarded by deputy Sheriff Handcuffs Not restraint</p> <p>Attachment B: Staff Competency for the Safe Use of Restraint</p> <p>A. In order to minimize the use of restraint, all direct care staff as well as any other staff involved in the use of restraint receive ongoing training and demonstrate an understanding of:</p> <ul style="list-style-type: none"> ·the difference between medical restraint and behavioral health restraint ·when a device is considered restraint and when it is considered part of a procedure ·the possible alternatives to the use of restraint ·observed actions or behaviors that may warrant the need for restraint ·the undesired and desired outcomes of restraint use ·the patient's rights in regard to restraint use ·the safe application of restraint devices for nurses only (CNA's are not permitted to apply restraints but may assist) ·15 min safety checks can be done by any staff member ·2 hour assessment must be done by the nurse NOT the CNA <p>B. Additional training is required for staff who monitor, assess, and evaluate the patient in restraint and includes an understanding of</p> <ul style="list-style-type: none"> ·the physician orders and assessment requirements for patients in restraint ·the documentation of the care 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>and monitoring of the patient</p> <ul style="list-style-type: none"> ·taking vital signs and interpreting their relevance to the physical safety of the patient ·recognizing nutrition/hydration needs ·checking circulation and range of motion in the extremities ·addressing hygiene and elimination ·addressing physical and psychological status and comfort ·assisting patients in meeting criteria for the discontinuation of restraint ·recognition of the need to contact a physician to evaluate/treat the patient's physical status ·debriefing of the incident with staff, family, patient will occur as soon as possible after the episode, no longer than 24 hours . C. Additional training is required for staff who care for, apply, or evaluate patients in behavioral health restraint including an understanding of <ul style="list-style-type: none"> ·the underlying causes of threatening behaviors exhibited by the patients they serve ·aggressive behavior that may be related to the patient's medical condition ·how their own behavior can affect the behaviors of the patients they serve ·the use of de-escalation, mediation, self-protection, and other techniques, such as time-out 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000396	<p>482.23(b)(4) NURSING CARE PLAN</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan</p> <p>Based on document review and staff interview, the nursing staff failed to develop a complete nursing care plan for 4 of 7 patients (patients 1, 8, 10, and 11) and failed to review the care plan per policy for 4 of 7 patients (patients 1, 8, 9, 10).</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record indicated the following: (A) The care plan did not include interventions to reach the documented goal. Nursing staff documented the patients current behavior in the intervention section instead of what interventions were to be used to reach the stated goal. (B) The complete care plan was not reviewed per policy for > 24 hours on 4/7/14-4/8/14.</p> <p>2. Review of patient #8 medical record indicated the following: (A) The care plan did not include interventions to reach the documented goal. Nursing staff documented a goal in</p>	A000396	<p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A396 DATE DEFICIENCY WILL BE CORRECTED: 7-7-14</p> <p>WHAT IS THE PLAN OF CORRECTION: Daily chart checks that were being done by the nursing staff will be replaced with daily chart audits that will be performed by the house supervisors. This will ensure that each patient has a Health care Plan with clearly stated problems, interventions, and reasonable goals. This will also ensure that the HCP is reviewed and updated every 24 hours by an RN.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Daily Chart audits will be developed by the CNO, Quality Director and Informatics nurse and will address compliance with RN care plan oversight, completion of necessary assessment tools, MD orders, critical lab follow up and</p>	07/07/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>the intervention section instead of an intervention. (B) The complete care plan was not reviewed per policy for > 24 hours on 6/1/14-6/2/14.</p> <p>3. Review of patient #9 medical record indicated the following: (A) The care plan was not reviewed per policy for > 24 hours on 6/1/4-6/2/14.</p> <p>4. Review of patient #10 medical record indicated the following: (A) The care plan did not include interventions to reach the documented goal. Nursing staff documented a goal in the intervention section instead of an intervention. (B) The complete care plan was not documented as reviewed 5/28/14-6/2/14.</p> <p>5. Review of patient #11 medical record indicated the following: (A) The care plan did not include interventions to reach the documented goal. Nursing staff documented the patients current behavior in the intervention section instead of what interventions were to be used to reach the stated goal.</p> <p>6. Facility policy titled "ASSESSMENT, RE-ASSESSMENT, & DATA COLLECTION" last reviewed/ revised</p>		<p>overall nursing documentation. The night shift House Supervisors will be educated on the use of the audit tool and perform audits on all patient that are inpatient on BHS or Medical Surgical units every night. These audits will be turned into the Quality Director and reported to the Quality Council every month for the next 3 months.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director; Krista Hall RN, Informatics Nurse</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The Daily Chart Audit tool will be completed by 6/20/14. Education on the use of this audit tool will be completed by 7/10/14.</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The Quality Director will review the Audit Tools every day to ensure completion and will report the findings to the CNO or Unit</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>7/13 stated on page 3: "1.....An RN will review the plan of care at least once every 24 hours....."</p> <p>7. Staff member #N3, Director of Emergency Department, verified the medical record information for patient #1 beginning at 11:00 a.m. on 6/3/14.</p> <p>8. Staff member #N2, Medical/Surgical Staff Nurse, verified the medical record information for patients #8 and 9 beginning at 2:55 p.m. on 6/3/14.</p> <p>9. Staff member #N16, Behavior health Unit Licensed Practical Nurse, verified the medical record information for patients 10 and 11 beginning at 11:40 a.m. on 6/4/14.</p>		<p>Director as needed for follow up daily and to the Quality Council every month.</p> <p><u>CHART AUDITS</u></p> <p>DATE:</p> <p>_____</p> <p>SUPERVISOR:</p> <p>_____</p> <p>_____</p> <p>ACCT # TIME ANTIBIOTIC STARTED AFTER MD ORDER</p> <p>ALL MD ORDERS COM-PLETED OR NOTED MD H+P DONE WITHIN 24 HOURS ALLERGY SECTION COMPLETED LAB: ADMIT & CRITICAL LEVELS MD NOTIFIED WITH NURSE DOCUMENTATION NUTRI-TION</p> <p>FORM COM- PLETED</p> <p>ADMIT: NURSE</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
			PHYSICAL ASSESSMENT COMPLETED AND INITIAL INTERVIEW COMPLETED NURSE DAILY CHARTING DONE INITIAL BODY CHECK FOR BHS COMPLETED RN CARE PLAN PROBLEM INTERVENTION AND GOALS COMPLETED WEIGHT AND V/S AS ORDERED BY MD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000397	482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>competence of the nursing staff available. Based on document review & interview the facility failed to ensure that nursing personnel completed unit specific competencies on the inpatient Behavioral Health unit for 7 of 15 personnel files reviewed (Staff #N1, N7, N9, N11, N16, N17 & N20).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the Job Descriptions for a registered nurse (RN) and a licensed practical nurse (LPN) on the Med Surg (Medical Surgical) / BHS (Behavioral Health) unit indicated the following: "9. Successfully complete facility conducted orientation of specialized dementia unit as appropriate." Review of staff #N1, N7, N9, N11, N16, N17 & N20's personnel files indicated each was either a RN or LPN and worked on the BHS unit. Each file lacked documentation completing the facility conducted orientation of specialized dementia unit. On 06-05-14 at 1150 hours, the facility conducted orientation of specialized dementia unit documentation was requested from staff #41. No documentation was provided prior to exit. 	A000397	<p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A397 DATE DEFICIENCY WILL BE CORRECTED: 7-10-14</p> <p>WHAT IS THE PLAN OF CORRECTION: All staff assigned to work on the BHS unit will have Department Specific orientation to the unit to ensure that the patient's needs are being met in accordance with the qualifications and competence of the staff.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: The Nursing Education nurse will audit the education files of all the nursing staff and ensure that they have documentation present in their file of department specific orientation to BHS. If this orientation documentation is not present, the orientation will be performed and documented in their file.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and NE; Beth Fisher RN, Unit</p>	07/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000405	<p>482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS</p> <p>(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.</p> <p>(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.</p>		<p>Director; Doug Lee, Human Resources.</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: All clinical staff will be oriented to the BHS unit during the orientation process in their first 90 days of employment with Saint Catherine Regional Hospital. They will not be allowed to come out of orientation until this documentation is in their employee education file.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. Based on document review and staff interview, the facility failed to ensure medications were administered in accordance with physician order for 1 of 5 patients with pain medication orders (patient #26).</p> <p>Findings include:</p> <p>1. Review of patient #26 medical record indicated the following: (A) The patient presented to the hospital via ambulance at 1300 on 4/24/14 with complaint of chest pain. (B) An order was written at 1608 on 4/24/14 for Neurontin 300 mg tid (three times a day). (D) The medical record lacked evidence that the Neurontin was administered on 4/24/14.</p> <p>2. Staff member #AA1, Director of Medical Records, verified the medical record information at 12:15 p.m. on 6/5/14.</p>	A000405	<p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.23- Administration of Drugs</p> <p>ID PREFIX TAG: A405</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7-10-14</p> <p>WHAT IS THE PLAN OF CORRECTION: All medications at Saint Catherine Regional Hospital will be administered in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Education will be provided to the Nursing staff, Cardio-pulmonary staff, and Radiology staff on the policy and procedure for medication</p>	07/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>administration and required documentation for Saint Catherine regional Hospital. All medications administered at Saint Catherine Regional Hospital will be given according to the Policy and Procedure. If a medication falls outside the compliance parameters; proper documentation for variance and the notification of doctor, family and patient will be provided in the medical record as applicable. The EHR will identify medications falling outside compliance and the Informatics Nurse will run a report every morning, Monday through Friday, and provide a copy of this report to the Unit Director/Manager for follow up with staff. Implementation of the EHR system went into effect 7/3/14. Programming for the EHR will eventually end with "real time" encrypted notification to the Unit Director/Managers so medications administered outside the compliance parameter can be identified and addressed immediately.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director;</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Krista Hall RN, Informatics Nurse, Lisa Maddox, Radiology Director, Clark Daniels, Cardiopulmonary Director.</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The implementation of the EHR system will ensure the accuracy and timeliness of medication administration through the use of warning messages and forward moving blocks for any situation which falls outside the parameters of normal medication administration, which takes into account the 5 rights of medication administration. This system is live and currently in use in the facility. All current staff will be educated on the Saint Catherine Regional Hospital Policy and Procedure for Medication Administration and this Policy and Procedure will be added to the orientation checklist for new hires and reviewed yearly during the annual nursing competencies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Adherence to the Medication Administration Policy and Procedure will be monitored on an ongoing basis by the Unit Directors/Managers. The EHR will identify medications falling outside compliance and the Informatics Nurse will run a report every morning, Monday through Friday, and provide a copy of this report to the Unit Director/Manager. The Unit Directors/Managers will review this report and follow up with identified issues accordingly. This process will be reported at the monthly Quality Council meeting for 3 months, beginning in September.</p> <p>ST. CATHERINE REGIONAL HOSPITAL</p> <p>SUBJECT: MEDICATION ADMINISTRATION GUIDELINES REFERENCE #</p> <p>PAGE: 1 DEPARTMENT: NURSING, CARDIOPULMONARY, RADIOLOGY OF: 3</p> <p>EFFECTIVE: 9/05 APPROVED BY: CNO, DIRECTOR OF PHARMACY REVISED: 9/02, 7/04, 9/04, 9/05, 4/14, 6/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>PURPOSE:</p> <p>To guide the health care workers in accurate and safe administration of medications.</p> <p>POLICY:</p> <p>Medications shall be administered only upon the order of a member of the Medical Staff, an authorized member of the hospital staff, or other individuals who have been granted clinical privileges to write such orders. All medications shall be administered by, or under the supervision of appropriately licensed personnel in accordance with the Nursing, Medical Staff, Cardiopulmonary, and Radiology policies.</p> <p>The self-administration of medication by the patient shall be permitted on a specific written order by the authorized prescribing practitioner/physician and in accordance with established hospital policy.</p> <p>All drugs, which are administered to a patient, shall be charted in the patient's clinical record to maintain accurate records and to ensure correct billing to the patient.</p> <p>Medications can be administered by the Medical staff, Nursing staff (RN and LPN), Cardiopulmonary Services, and Radiology staff.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>No one shall be required to administer a medication that is believed to be outside the scope of his or her practice or of such excessive dosage that it is considered unsafe. Incidents of this type should be reported to the supervisor and documented on a variance report.</p> <p>PROCEDURE:</p> <p>Pre Administration</p> <ol style="list-style-type: none"> 1. Verify the order in the clinical record. 2. Check allergy information. Allergy information must be documented in the clinical record. 3. Make sure the label on the medication agrees with the medication order. Read the label again before opening the container or unwrapping the package. 4. Scan your employee bar code 5. Observe package directions, i.e., shake well, dilute, etc. 6. Pour liquids at eye level. 7. Leave unit dose packages unopened until administration. 8. The practitioner preparing or removing the medication is the one responsible for administering it. NO HAND-OFFS. <p>ADMINISTRATION:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
			<ol style="list-style-type: none"> 1. No drugs are to be administered by anyone other than licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe. 2. Administer medication within one (1) hour of designated time. 3. Confirm the patient's identity by asking his/her name and checking the name on the identification band. Scan the patient's identification band. The patient's birth date is the second identifier. 4. Scan the medication being administered. 5. Have second nurse or Pharmacy personel verify high risk medications. 6. Check for five "rights" each and every time a medication is administered: <ul style="list-style-type: none"> · Right patient · Right dose · Right route · Right frequency · Right time 7. Check the patient's allergies. 8. Educate the patient on medications being administered. 9. Observe the patient until the medications is taken. <p>Documentation:</p> <ol style="list-style-type: none"> 1. If the medication is withheld 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>or the patient refuses, document this in the clinical record and notify the MD.</p> <p>2. If a medication is new, assess the effect and patient response. Document the effect and response of the patient, as indicated in the clinical record.</p> <p>Home Medications and Self-Administration of Medications:</p> <p>Home medications:</p> <p>1. It is preferable to send patient medications home with a family member, if this is not possible, the patient's medications will be sent to the pharmacy in the medication security bag. They will be secured in the Pharmacy until discharge. Medications left in the Pharmacy after discharge will be kept for at least one month. After this period the medications will be destroyed.</p> <p>2. Medications from home may not be administered to the patient in the hospital unless:</p> <p>a. There is a written order by the physician in the patient's chart to administer them.</p> <p>b. A hospital pharmacist has identified the medication.</p> <p>3. Home medications will be kept in the patient's medication drawer and administered by the attending nurse.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Self-administration of "patients own" medications:</p> <ol style="list-style-type: none"> 1. The Physician must write a medication order for the medication's, dosage, frequency and route, as well as an order that the patient may "self-administer" the medication. 2. A hospital pharmacist, prior to use must identify the medication. 3. The medication administration record (MAR) will indicate that the medication from home is at the bedside. 4. The patient will be instructed to notify the nurse when he or she has taken the medication and proper documentation will be done on the medication administration record. 5. Prescription medications at the bedside must be labeled with the patient's name, medication, dosage, and instructions for taking the medication. OTC drugs may be labeled with the patient's name. <p>Read and Sign Date: _____ Review the Policy: Medication Administration Guidelines I have read and understand the policy for medication administration. I understand that I must document any medication given in the clinical record. I understand, also, that I must document any held or refused medication in the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000409	482.23(c)(4) BLOOD TRANSFUSIONS AND IV MEDICATIONS Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures. If		<p>clinical record and notify the physician. I know the 5 rights of medication and will check them before administering any medication, each and every time.</p> <p>PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</p> <p>Saint Catherine Regional Hospital</p> <p>BEHAVIORAL HEALTH DEPARTMENT ORIENTATION CHECKLIST RN/LPN EMPLOYEE NAME:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>blood transfusions and intravenous medications are administered by personnel other than doctors of medicine or osteopathy, the personnel must have special training for this duty.</p> <p>Based on blood transfusion policy reviews, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for fourteen (Patient #1-3, 6-7, 9-10, 13-15 and 17-20) of twenty patients.</p> <p>Findings include:</p> <p>1. On 6/03/14 at 1:40 p.m., review of the laboratory policy, "Blood and Blood Product Administration", revised 3/12, read: "Each person must initial or sign appropriate forms assuring that all identifiers match and are acceptable."</p> <p>2. On 6/03/14 at 1:50 p.m., review of the nursing policy, "Blood and Blood Product Administration", reviewed 11/07, read: "Blood and Blood products will be administered upon a physician's order. Nursing personnel will obtain a blood/blood product consent form. Laboratory technologist and person picking up the blood shall sign and date blood request and blood bank ledger.</p>	A000409	<p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A409</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 7-10-14</p> <p>WHAT IS THE PLAN OF CORRECTION: Administration of Blood or Blood products at Saint Catherine Regional Hospital will be done in accordance with federal and State laws and regulations, and in accordance with the hospital's Policies and Procedures.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: All nursing and laboratory staff will be educated on the Administration of Blood or Blood products Policy and Procedure upon hire and annually. Nursing staff will also have to complete a Blood or Blood product Competency prior to administering blood or blood products effective 7/3/14 regardless of previous training. No blood or blood product will be administrated</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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>Whole blood and Packed Cells must be initiated within 30 minutes of obtaining the blood from the laboratory and must infuse within 4 hours of leaving the blood bank refrigerator.</p> <p>Patients shall be frequently monitored for signs of adverse reactions, such as: chills or fever (temperature observation of 2 degree or more).</p> <p>Vital signs including temperature, pulse, respirations and blood pressure, and visual checks of the patient will be as follows: 15 minutes after the start of the infusion</p> <p>Whole blood and Packed Cells must be initiated within 30 minutes of obtaining the blood from the laboratory and must infuse within 4 hours of leaving the blood bank refrigerator.</p> <p>Lab personnel and nursing personnel will review the transfusion record and sign post transfusion data under section 3 of the transfusion record."</p> <p>3. On 6/04/14 at 2:00 p.m., review of twenty patients receiving blood units indicated fourteen of these received-units did not have complete documentation, per policy, on the Transfusion Record form including:</p> <p>Patient #1 Unit administered on 4/24/14 at 2100: The unit was started at 2100; however,</p>		<p>within this hospital without the knowledge and supervision of the House Supervisor, regardless of shift. The laboratory staff will perform ongoing QA monitoring of the Transfusion Record and Transfusion log to ensure completion and will communicate any deficiencies to the nursing supervisor.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Quality Director and NE; Clark Daniels, Laboratory Director; All House Supervisors and Lab Staff</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: Each and every administration will be supervised and reviewed by the House Supervisor using a Supervisor Transfusion Report which will be turned into the Quality Director after each infusion. These reports will be kept on file in the Quality Director's office. The House Supervisor will also notify the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>the 30 minute vitals were documented at 2130 in lieu of at 15 minutes (2115). Patient #2 Unit administered on 2/04/14 at 2130: The unit was released from the blood bank at 2000; however, it was administered at 1 hour and 30 minutes in lieu of within 30 minutes (2030). Patient #3 Unit administered on 1/24/14 at 2015: The unit was started at 2015 and the 15 minutes vitals were documented at 2027 which was 12 minutes; the unit was released from the blood bank at 1739 and completed at 2300 which was 5 hours and 21 minutes in lieu of within 4 hours (2139). Unit administered on 1/24/14 at 1755: The unit was started at 1755 and the 15 minute vitals were documented at 1710 which was prior to the start time on 1755. Patient #6 Unit administered on 12/05/13 at 2115: The transfusion record form was missing the tech signature signing time. Patient #7 Unit administered on 11/009/13 at 1800: The 15 minute vital temperature was 93.1 Fahrenheit (F) at 1816 and the vital temperature at completion at 1936 was 98.3 F (a rise of 5.2 degrees F). No adverse reaction had been documented for this temperature rise above 2 degrees F.</p>		<p>Unit Director and report the transfusion on the Daily Clinical report. Laboratory Director will report QA findings monthly in the Quality Council Meeting.</p> <p>Read and Sign NURSING</p> <p>Date: _____</p> <p>Review the Policy: Blood & Blood Product Administration- Plasma, Albumin, Platelets & Cryoprecipitate</p> <p>I have read and been given a copy of the policy for Blood and Blood product administration. I understand my responsibilities according to my scope of practice concerning this procedure. I will notify my House supervisor of any new order for Blood or Blood products or any complications or unusual events during a transfusion. I have completed the post test and returned it to the Nursing Education office located on the Medical Surgical floor. I</p>	
--	--	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Patient #9 Unit administered on 10/10/13 at 0725 and Unit administered on 10/10/14 at 0820 had been administered without benefit of a signed patient consent.</p> <p>Patient #10 Unit administered on 10/2/13 at 1515: The time the unit had been released from the blood bank had not been documented.</p> <p>Patient #13 Unit administered on 8/24/13 at 1235: The transfusion record form was missing the amount of blood transfused and the signature of the laboratory tech responsible for verifying the post transfusion data. The blood bank log was missing the time the unit had been cross matched.</p> <p>Unit administered on 8/24/13 at 1418: The pretransfusion vital temperature as 98.0 F and the 15 minute vital temperature was 98.7 F (a rise of 0.7 degrees F) however no adverse reaction documentation was available for review. The transfusion record form was missing the amount of blood transfused and both the signature of the Registered Nurse (RN) and laboratory tech responsible for verifying the post transfusion data. The blood bank log was missing the time the unit had been cross matched.</p> <p>Patient #14 Unit administered on 8/13/13 at 2015:</p>		<p>have taken the Competency sheet and will have my House Supervisor fill it out at the next opportunity. I will not transfuse Blood or Blood Products without the presence of my supervisor until my competency is completed and turned into Nursing Education.</p> <p>PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
	The unit was released from the blood bank at 1940 and started at 2015 which was greater than 30 minutes (35 minutes) Patient #15 Unit administered on 7/17/13 at 2140 and Unit administered on 7/17/13 at 2332 had each been administered without benefit of a physician's order. Patient #17 Unit administered on 6/28/13 at 1630 had been administered with no documentation of a signed patient consent. Unit administered on 6/28/13 at 2038: The unit was started at 2038 and the 15 minute vitals documented at 2048 which was 10 minutes in lieu of 15 minutes; This unit had also been administered with no documentation of a signed patient consent. Patient #18 Unit administered on 5/23/13 at 1025 and Unit administered on 5/23/13 at 1351 had each been administered without benefit of a signed patient consent. Patient #19 Unit administered on 5/09/13 at 2330 and Unit administered on 5/09/13 at 1645 had each been administered without benefit of a physician's order. Patient #20		6 7 8 9 10 11 12 13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Unit administered on 4/28/13 at 0350: The unit was started on 4/28/13 at 0350 and the 15 minute vitals documented at 0410 which was at 20 minutes in lieu of within 15 minutes.</p> <p>4. On 6/03/14 at 4:30 p.m., staff member #5 (registered nurse) acknowledged that missing documentation for the above-listed patient blood units was not available for review.</p>		<p>14</p> <p>15</p> <p>16</p> <p>Read and Sign HOUSE SUPERVISORS</p> <p>Date: _____</p> <p>Review the Policy: Blood & Blood Product Administration- Plasma, Albumin, Platelets & Cryoprecipitate</p> <p>I have read and been given a copy of the policy for Blood and Blood product administration. I understand my responsibilities according to my scope of practice concerning this procedure. I will monitor</p>	
--	---	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>any transfusion of Blood or Blood products administered during my shift and be available to the nursing staff as a resource. I will review the "Transfusion Record" for accuracy and completion when the transfusion is completed. I will complete a "Supervisor Transfusion Report" and turn this report into the Quality Director. I will report the transfusion on the "Daily Nursing Report" and notify the Unit Director.</p> <p style="text-align: center;">PRINT NAME SIGNATURE / TITLE DEPARTMENT</p> <p>1</p> <p>2</p> <p>3</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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
A000438	<p>482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>Based on observation, the facility failed to properly store medical records in a location where they were protected from fire in 1 instance.</p>	A000438	<p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>CMS PLAN OF CORRECTION</p> <p>ID PREFIX TAG: A438</p> <p>DATE DEFICIENCY WILL BE</p>	08/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>Findings:</p> <p>1. On 6-4-14 at 10:00 am, in the presence of employee #A3, Chief Executive Officer and employee #A6, Facility Director, it was observed in the medical record storage area, some of the paper records were stored on 7 shelves that were open on at least 2 sides (front and back). It was also observed the area did not have an automatic sprinkler system. If a fire occurred in that area, the records on those shelves were unprotected.</p>		<p>CORRECTED: 8/3/14 for phase one, 9/3/14 for phase two and completion</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital will maintain inpatient and outpatient medical records in a location where they are protected by fire.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: The Facilities Director will coordinate with the Medical records staff the movement of all 2013 to current medical records to a closed file cabinet. This will be completed by 8/3/2014. The facilities Director will then coordinate with the Medical Records staff to have the older records safely boxed and shipped to a secure storage facility off site.</p> <p>WHO IS RESPONSIBLE: Dave Millet, Facilities Director; Medical Records staff</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/10/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	
A000701	<p>482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. Based on observation, the facility failed to maintain the hospital's environment to assure the well-being of patients in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 6-4-14 at 10:25 am, in the presence of employee #A3, CEO, and employee #A6, Facility Director, it was observed in the mammography area there was a considerable amount of dust on the equipment. On 6-4-14 at 10:30 am, in the presence of employee #A3, Chief Executive Officer, and employee #A6, 	A000701	<p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: All paper medical records will be stored in closed, non-flammable, cabinets within the hospital or placed in secure storage. The implementation of the Empower EHR system on 7/3/14 will ensure minimal paper record generation for future patients.</p> <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A701 DATE DEFICIENCY WILL BE CORRECTED: 7-10-14 WHAT IS THE PLAN OF CORRECTION: The physical plant and overall hospital environment will be maintained in such a manner that the safety and well-being of patients are assured. HOW THE PLAN OF CORRECTION WILL OCCUR: The daily dusting of the Mammography machine, CT scanner, Radiology and Housekeeping staff lockers will be done by the housekeeping staff as part of their daily work assignment. WHO IS RESPONSIBLE:</p>	07/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(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			
A000724	<p>Facility Director, it was observed in the computerized tomography scan area, there was a large amount of dust on the equipment.</p> <p>3. On 6-4-14 at 10:45 am, in the presence of employee #A3, Chief Executive Officer, and employee #A6, Facility Director, it was observed in the radiology area, there was a large amount of dust on the lockers.</p> <p>4. On 6-4-14 at 11:10 am, in the presence of employee #A3, Chief Executive Officer, and employee #A6, Facility Director, it was observed in the housekeeping storage area, there was a large amount of dust on the employee lockers.</p> <p>482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. Based on review of the manufacturer's instrument manual,</p>	A000724	<p>Ginger Ottersbach RN, CNO; Kimmie C.Perra RN, Infection Control nurse; Dave millet, Facilities Director WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/10/14 HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED: The dusting of the Mammography machine, CT scanner, Radiology and House keeping staff lockers will be added to the daily work check off sheet which is completed by the housekeeping staff as the work is performed daily. This check off is monitored daily by the House Keeping supervisor and any deficiencies are corrected at the time they are discovered.</p> <p>CMS PLAN OF CORRECTION ID PREFIX TAG: A724</p>	07/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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>patient test results, observation and staff interview, the laboratory did not demonstrate that it could obtain performance specifications comparable to those established by the manufacturer in the upper linear test reportable range indices (complete blood count-CBC) for one of six specialities (Hematology) and the facility failed to store a piece of equipment in a manner to ensure an acceptable level of safety in 1 instance and failed to maintain 2 pieces of equipment.</p> <p>Findings included:</p> <p>1. On 6/05/14 at 10:15 a.m., review of the manufacturer's operator's manual for the LH 500 analyzer, used for CBC testing which included white blood count (WBC), red blood count (RBC), Hemoglobin (Hgb), and Platelet (Plt), approved 9/14/12, read:</p> <p>Parameter Linearity Range Achieved upper limit-Units WBC 0.0-200.0 Not</p>		<p>DATE DEFICIENCY WILL BE CORRECTED: 7/10/14</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital will ensure that all facilities, supplies and equipment are maintained in an acceptable level of safety and quality.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: A Periodical Maintenance Program will be developed by the Facilities Director for the parallel bars and wooden stair steps located in the Physical Therapy Department. This PM will be kept on file in the Facilities Director office and performed by the maintenance staff. The compressed air tank in the Cardiopulmonary Department has been secured by a chain which was installed 6/23/14.</p> <p>WHO IS RESPONSIBLE: Dave millet, Facilities Director; Maintenance Staff</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/10/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>Available cells/uL</p> <p>RBC 0.00-7.00 Not</p> <p>Available cells/uL</p> <p>Hemoglobin 0.00-25.0 Not</p> <p>Available g/dL</p> <p>Plt 0 - 2000 Not</p> <p>Available cells/uL</p> <p>Legends: K/uL (thousand per microliter) g/dL (gram per deciliter)"</p> <p>2. On 6/05/14 at 10:00 a.m., staff member #8 (laboratorian) acknowledged that, through interview and upon request, the above-listed documentation of the upper performance limitations of each CBC indices listed by the manufacturer had not been documented and achieved by the LH 500 analyzer in Hematology</p> <p>3. On 6-4-14 at 10:10 am, in the presence of employee #A3, Chief Executive Officer, and employee #A6, Facility Director, it was observed in the cardiopulmonary storage area that there was a large compressed gas tank cylinder stored upright on the floor that was not</p>		<p>HOW THE DEFICIENCY REOCCURANCE WILL BE PREVENTED: The Parallel bars and wooden stair steps will be visually checked daily on the Environmental rounds performed by the maintenance staff and repaired as needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
---	--

(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>secured by chain or holder. If the tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>4. On 6-4-14 at 10:15 am, in the presence of employee #A3, Chief Executive Officer, and employee #A6, Facility Director, it was observed in the physical therapy area that there were parallel bars and wooden stairstep equipment. Employee #A3, CEO was requested to provide documentation of a periodical maintenance program for the equipment.</p> <p>5. In interview, on 6-5-14 at 3:00 pm, employee #A6, Facility Director, indicated there was no documentation of a periodical maintenance program for the above-stated equipment and no further documentation was provided prior to exit.</p>			

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

PRINTED: 09/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
(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	