

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155373	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2015
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NAME OF PROVIDER OR SUPPLIER  BLUFFTON REGIONAL MEDICAL CENTER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 15, 16, 17, 18 and 19, 2015.</p> <p>Facility number: 000264 Provider number: 1555373 AIM number: N/A</p> <p>Census bed type: SNF: 7 Total: 7</p> <p>Census payor type: Medicare: 7 Total: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and</p>	F 0323	The Director of Nursing determined that no resident had any harm or	06/19/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>record review, the facility failed to ensure safe and/or comfortable water temperatures were maintained for 6 of 7 occupied resident rooms and unit shower room. (Room #1014,1016,1010,1012,1018,1020)</p> <p>Findings include:</p> <p>1. On 6/15/15 at 2:41 p.m., the following water temperatures were obtained with two ISDH (Indiana State Department of Health) thermometers: Rm (room) 1014: 124.2 (degrees) F (Fahrenheit); Rm 1016: 124.3 F; Rm 1010: 110 F; Rm 1012:108 F; Rm 1018: 124.2 F; Rm 1020: 122.5 F.</p> <p>On 6/15/15 at 3:28 p.m., the water temperature, from the sink in the only shower room on the unit, was obtained with an ISDH thermometer. The result was 125.4 F.</p> <p>On 6/15/15 at 4 p.m., Maintenance Man #1 was interviewed. He indicated he worked the evening shift and was unsure how often the water temperatures were checked. At 4:11 p.m., Maintenance Man #1 obtained the following water temperatures with the facility thermometer: Rm 1010: 110.6 F; Rm 1012: 124.2 F; Rm 1016: 124 F. Room 1014 had a temperature obtained while</p>		<p>skin issues from the water temperature on the Continuing Care Unit. The Plant Operations director is responsible for the water temperature of the Continuing Care Unit being maintained within the range of 100-120 degrees. The Plant Operations Director adjusted the temperature of the water heater affecting the Continuing Care Unit. The Plant Operations Director revised the preventive maintenance work order to test the water temperature and report any out of range findings immediately to the plant operations department. The EVS associate was retrained on collecting an accurate water temperature reading. Measures of Prevent Reoccurrence The Plant Operations Director conducted an inservice on monitoring of water temperature and appropriate steps to take when temperature is out of range. The Plant Operations Director will conduct daily observations from July 6-10 then weekly observations for domestic hot water temperatures within the desired range. The Plant Operations Director will conduct daily observations on the water heater for the skilled care unit. Findings will be presented at CCC quarterly meeting and Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees for 6 months and then only if out of range temperatures are observed.</p>		

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	<p>the thermometer was held underneath a running stream of water and the temperature was observed to vary from 110.2 F down to 101.9 F and back up to 110 F. Maintenance Man #1 indicated the variance observed in water temperature was over a period of 3 minutes. In Rm 1020, Maintenance Man #1 obtained a water temperature of 123 F - 122 F - 123.5 F over a period of 1 1/2 minutes as the stream of water ran into a cup. The water from the shower was checked with Maintenance Man #1's thermometer and a temperature of 107.6 F was obtained. Maintenance Man #1 indicated the variance in water temperature was due to the length of time the water had been in the water line. He indicated the boiler was located in the basement, about 75 feet from the long term care unit.</p> <p>On 6/15/15 at 4:15 p.m., Maintenance Man #1 was interviewed. He indicated the desired water temperature was to be "120 degrees F, I guess..I don't want anyone to get burned...125 degrees F max (maximum) I guess..."</p> <p>On 6/15/15 at 4:44 p.m., the DON (Director of Nursing) was made aware of the actual highest water temp of 125.4 F. She indicated she was not aware of the acceptable water temperature ranges but</p>			

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	<p>the housekeeping staff checked the water temps (temperatures). She indicated the maintenance department was aware of the acceptable water temperatures.</p> <p>On 6/16/15 at 8:55 a.m., the following water temperatures were obtained with two ISDH thermometers: Rm 1020: 125.8 F; shower room sink: 126.1 F; Rm 1014: 124.2 F as the water ran for 1 1/2 minutes. At 9:55 a.m. Rm 1016: 124.7 F; Rm 1012 was observed to have a temperature range of 107 F-105 F and Rm 1010 had a temperature range of 70 F-106 F.</p> <p>On 6/16/15 at 10:18 a.m., Maintenance Man #2 checked the water temperature of the sink in the shower room with his thermometer. He obtained a temperature of 121.9 F while holding the thermometer in the stream of running water. At 10:22 a.m., the temperature was rechecked while placing a cup in the basin of the sink so the water could collect in the cup. The maintenance man's thermometer was placed in the cup and a temperature of 124.1 F was obtained. The maintenance man was interviewed and indicated he wasn't sure how often the water temperatures were checked. He indicated Housekeeper #1 obtained the water temperatures on this unit. He indicated the hot water heater temperature for this</p>			

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	<p>unit was set at 125 degrees F as they "expect to see a little loss." He indicated he would expect to see the water temperatures between 120-125 degrees. The following water temperatures were obtained with Maintenance Man #2's thermometer while water ran in a cup in the following rooms: Rm 1020 at 10:30 a.m.: 124.4 F; Rm 1016 at 10:31 a.m. tested at 123.1 F; Rm 1014 at 10:32 a.m. 124.6 F; Rm 1012 at 10:34 a.m.: 121.3 F; Rm 1010 at 10:35 a.m.: 120.6 F.</p> <p>On 6/16/15 at 10:37 a.m., the Plant Operations Manager was interviewed. He indicated this facility was an old building and there were some fluctuations in the water temperatures. He indicated housekeeping staff obtained the water temperatures weekly and these were documented on the "Preventative Maintenance Work Order" form. He indicated they "like to keep the temperatures of water between 120-124 F." He indicated the water temperatures on the units were recorded weekly. He indicated the acceptable minimum water temperature would be 110 F.</p> <p>On 6/16 15 at 10:45 a.m., Housekeeper #1 was interviewed. She indicated she checked the water temperatures weekly of 3 resident rooms. She indicated she checked the resident rooms whose water</p>			

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	<p>"tested the hottest", which were typically Rms 1016 and 1018. She indicated the water temperatures in these rooms "usually run around 122 F."</p> <p>On 6/16/15 at 11:53 a.m., the DON provided a copy of the completed weekly "Preventative Maintenance Work Order" forms, for the dates of 3/14/15 - 6/13/15. The following temperatures were documented on the following dates:</p> <p>On 3/14/15: Rm 1018: 123 F; Rm 1010: 101.                      On 3/21/15: Rm 1016: 124 F; Rm 1012: 82.                      On 3/28/15: Rm 1018: 122 F; Rm 1010: 99 F.                      On 4/4/15: Rm 1018: 124 F; Rm 1012: 102 F.                      On 4/11/15: Rm 1016: 125 F; Rm 1010: 98 F.                      On 4/18/15: Rm 1018: 124 F; Rm 1012: 99 F.                      On 4/25/15: Rm 1016: 124 F; Rm 1012: 102 F.                      On 5/2/15: Rm 1016: 125 F; Rm 1010: 101 F.                      On 5/9/15: Rm 1016: 124 F; Rm 1012: 100 F.                      On 5/16/15: Rm 1018: 124 F; Rm 1012: 101 F.                      On 5/23/15: Rm 1018: 123 F; Rm 1012: 92 F.                      On 5/30/15: Rm 1020: 122 F; Rm 1012:</p>			

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	<p>101 F. On 6/6/15: Rm 1016: 123 F; Rm 1010: 98 F. On 6/13/15: Rm 1016: 120 F; Rm 1010: 96 F.</p> <p>On 6/16/15 at 2:55 p.m., the Plant Operations Manager was interviewed. He indicated the water temperature of the boiler would be turned down now. He indicated it would "take some time for the lower temperature water to circulate throughout the system." He indicated he would have his evening shift staff check the water temperatures this evening to ensure they are going down. He indicated also the cooler water temps may become more of a problem. He indicated he would notify an outside company to assist in having the problem fixed. At this time, he was also made aware of the water temperatures obtained with a result below 110 F. He indicated the facility would be checking the water temperatures routinely to ensure the water temperatures were safe.</p> <p>On 6/17/15 at 9 a.m., Housekeeper #1 was interviewed. She indicated she, "just checks the water temperatures on the unit and write them down. I turn the paper into the maintenance department." She indicated she was unaware what the "target" water temperatures should be.</p>			
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	<p>She indicated, "At one time the highest water temperatures she read were 122 F." At this time, she was made aware of the documented water temperatures on the "Preventative Maintenance Work Orders" over 122 F. Housekeeper #1 indicated "That would have been me because I'm the one who takes the water temperatures."</p> <p>On 6/19/15 at 10 a.m., the DON was interviewed. She indicated on 6/15/15, all of the residents on the unit were considered alert and oriented.</p> <p>On 6/19/15 at 10:40 a.m., the Plant Operations Manager was interviewed. He indicated yesterday, 6/18/15, they determined which heater fed the long term care unit and adjusted the correct heater temperature down to 115 F. He indicated they have a clear picture now of which water heater feeds which area. He indicated the desirable water temperature range would be 100-120 degrees F. He indicated the facility had been checking the water temperatures more frequently since they were made aware of the issue and they would continue to do so until the water temperatures stabilized. He indicated he would try to find a print for room 1010 and room 1012 to address the cooler water temperatures. He indicated he would call a company to come and</p>			

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	<p>"balance the system." He indicated the temperature of the water heaters were checked daily and they were logged. He indicated the water temperatures on the unit were checked weekly and these were logged as well. He indicated if the water temperatures "were too low" or " were too high " Housekeeper #1 would let them know.</p> <p>2. During an observation of Room 1010's bathroom on 6/15/15 at 3:35 p.m., the water temperature was cool to the touch after running the water for a few minutes.</p> <p>An interview with the Resident who resided in Room 1010, on 6/15/14 at 3:38 p.m., indicated the water never got very warm even after letting the water run for a while.</p> <p>On 6/15/15 at 3:48 p.m., the water temperature was measured with a digital thermometer in Room 1010's bathroom sink. The water temperature measured 88.0 degrees F (Fahrenheit) and immediately dropped to 70.4 degrees F. The water temperature slowly began to rise and after the water ran in the sink for 4 minutes the temperature of the water was 104.4 degrees F. and within seconds the water temperature dropped to 104.2 degrees F.</p>			

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F 0371	<p>On 6/16/15 at 1:36 p.m., the DON provided a current copy of the facility policy and procedure for "Domestic Water Temperature Policy," dated 8/26/14, which included but was not limited to, the following: "Policy: It is the policy of Bluffton Regional Medical Center (BRMC) to ensure the safety of patients and associates by regulating hot water temperature, in accordance with State Health Department Regulations. Purpose: The purpose of this policy is to inform associates of the maximum allowable hot water temperature in BRMC. Responsibility: Plant Operations, All staff; Procedure: The temperature of hot water used by patients (domestic hot water) in BRMC shall be maintained in accordance with state health department regulations (DOH). Absent state regulations, the following limits shall apply: 95-110 degrees Fahrenheit in residential treatment buildings/spaces (e.g. Nursing Homes and Long Term Care Units) ...The temperature of domestic hot water is tested weekly by environmental services and results submitted to the Plant Operations department. "</p> <p>3.1-45(a)(1)</p> <p>483.35(i)</p>			

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SS=E Bldg. 00	<p><b>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b> The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure staff washed their hands or performed hand hygiene after touching contaminated surfaces and prior to handling silverware to cut up meat on a resident's meal tray. The facility also failed to ensure food was covered on the meal tray to protect it from possible contamination prior to delivering the tray to the resident rooms. These deficient practices affected 4 of the 7 residents who had meals delivered to their rooms and had the potential to affect the 7 of 7 residents currently residing on the unit. (rooms 1016, 1014, 1012 and 1020)</p> <p>Findings include:</p> <p>1. An observation in the kitchen on 6-17-2015 at 11:27 a.m., indicated Nutrition Services #5 placed a meal tray in the covered metal cart for delivery to room 1016. Nutrition Services #5 used her hands to push the metal cart and with her hands opened the door of the kitchen, the double doors of the common hallway, pushed the elevator call button, the</p>	F 0371	<p>The Director of Nursing determined that no resident had any harm or signs of any food borne illnesses on the Continuing Care Unit.</p> <p>The Director of Nutritional Service is responsible for the food being covered appropriately when served to residents and the hand hygiene of the nutritional services staff. The Director of Nursing is responsible for the appropriate hand hygiene for the staff on the continuing care unit.</p> <p>Measures of Prevent Reoccurrence The Director of Nutritional Services conducted an inservice on hand hygiene and meal tray preparation. The Director of Nursing will conduct weekly observations for hand hygiene during meal service weekly for the next 6 months or until 100% compliance is met. The weekly observations will included different shifts and different meal times. Findings will be presented at CCC quarterly meeting and Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.</p> <p>The Director of Nursing conducted an inservice on hand hygiene and meal tray preparation. The Director</p>	07/08/2015

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	<p>elevator floor button and opened the door to the Continuing Care Unit. Once on the 1st floor, the metal cart was pushed to room 1016. The tray was removed and carried into the resident's room.</p> <p>Nutrition Services #5 removed the call light from the overbed table and placed the meal tray on the overbed table.</p> <p>Nutrition Services #5 moved the overbed table to the resident and lowered the table with her hands. Without handwashing or performing hand hygiene, Nutrition Services #5 unwrapped the silverware and cut up the resident's meat.</p> <p>An observation in the kitchen on 6-18-2015 at 11:47 a.m., indicated Nutrition Services #6 placed a meal tray for Room 1016 in the covered metal cart for delivery to room 1016. Nutrition Services #6 used her hands to push the metal cart and with her hands opened the door of the kitchen, the double doors of the common hallway, pushed the elevator call button, the elevator floor button and opened the door to the Continuing Care Unit. Once on the 1st floor, the metal cart was pushed to room 1016, the tray removed and carried a few steps in the common hallway with uncovered dishes of peaches and pudding.</p> <p>An observation on 6-18-215 at 11:50 a.m., indicated RN #9 entered room</p>		<p>of Nursing will conduct weekly observations for hand hygiene during meal service weekly for the next 6 months or until 100% compliance is met. The weekly observations will included different shifts and different meal times.</p> <p>Findings will be presented at CCC quarterly meeting and Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.</p>	

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	<p>1016. Without handwashing or hand hygiene, RN #9 donned gloves, unwrapped the resident's silverware and began to cut up the resident's meat.</p> <p>An observation in the kitchen on 6-18-2015 at 11:56 a.m., indicated the tray for room 1020 was placed in the metal cart with an uncovered dish of fruit.</p> <p>An additional observation indicated the meal tray for room 1014 was already in the delivery cart with uncovered dishes of pudding, applesauce and cottage cheese on the tray.</p> <p>An observation of meal delivery service on 6-18-2015 at 12:00 p.m., indicated Nutrition Services #6 used her hands to push the metal cart and with her hands opened the door of the kitchen, the double doors of the common hallway, pushed the elevator call button, the elevator floor button and opened the door to the Continuing Care Unit. Once in the unit, the metal cart was pushed to room 1014. Nutrition Services #6 was observed to obtain the tray for room 1014 from the metal cart and carried the meal tray a few steps in the common hallway with the uncovered dishes of pudding, applesauce and cottage cheese and delivered the tray to the resident in the room. Nutrition Services #6 was then</p>			

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	<p>observed to push the metal cart down the common hall and parked it across the hall and down from room 1020. Further observation of Nutrition Services #6 indicated, she removed the meal tray for room 1020 from the metal cart and carried the meal tray with the uncovered fruit several steps down the common hallway to the resident in room 1016.</p> <p>An observation in the kitchen on 6-19-2015 at 8:00 a.m., indicated Nutrition Services #5 was preparing breakfast trays for rooms 1012 and 1020. The tray for room 1020 was observed to have an uncovered dish of cottage cheese on it. All 3 meal trays were observed to be placed in the metal cart.</p> <p>An observation of the meal delivery service on 6-19-2015 at 8:04 a.m., indicated Nutrition Services #6 used her hands to push the metal cart and with her hands, opened the door of the kitchen, the double doors of the common hallway, push the elevator call button, the elevator floor button and opened the door to the Continuing Care Unit. Once on the unit, Nutrition Services #6 parked the metal cart between rooms 1012 and 1014. An observation on 6-19-2015 at 8:06 a.m., indicated Nutrition Services #6 removed the tray for room 1012 from the metal cart and delivered the tray to the room.</p>			

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	<p>Nutrition Services #6 was observed to leave the room to obtain a cup from the unit kitchen. Nutrition Services #6 returned to room 1012 with a small uncovered styrofoam cup and was observed to remove the lid from the tomato juice and pour some of the tomato juice into the styrofoam cup. No handwashing or hand hygiene was observed prior to pouring the tomato juice.</p> <p>An observation on 6-19-2015 at 8:08 a.m., indicated Nutrition Services #6 opened the metal cart and obtained a tray for room 1020. Nutrition Services #6 carried the tray with the uncovered cottage cheese several steps down the common hallway to the resident in room 1020.</p> <p>2. An interview with the Dietary Manager on 6-19-2015 at 8:11 a.m., indicated the meal delivery staff should wash their hands when returning to the kitchen and should perform hand hygiene or handwashing each time after leaving a resident's room and before cutting up resident's food. Further interview with the Dietary Manager, indicated she was unsure about covering the side dishes of applesauce, cottage cheese and fruits or salads and would need to check.</p>			

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	<p>An interview with QMA #8 on 6-19-2015 at 8:15 a.m., indicated hands should be washed prior to cutting up a resident's food and hand hygiene/handwashing should be done after assisting a resident with their meal.</p> <p>An interview with Nutrition Services #6 on 6-19-2015 at 8:47 a.m., indicated handwashing should be done when going into the kitchen and hand hygiene should be done after delivering each tray to the resident. Further interview with Nutrition Services #6, indicated she would wash her hands after every 4 or 5 meal trays were delivered.</p> <p>A current policy "Hand Hygiene" dated 1/14 and provided by the Director of Quality on 6-19-2015 at 11:45 a.m., indicated "...all associates associated with the handling of food shall wash hands...at the following times...after any other activity that may contaminate the hands...while on the nursing units...alcohol-based hand sanitizer is used to decontaminate hands when there is no visible soiling of the hands...associates who are unable to wash their hands often with soap and water must have access to hand sanitizer...these associates have job duties that limit their access to soap and water, work in remote work stations and/or have ongoing</p>			

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F 0520 SS=E Bldg. 00	<p>contact with guest high-hand-touch surfaces...."</p> <p>A current policy "Tray Assembly Procedures and GR* Start" dated 1/15 and provided by the Director of Quality on 6-19-2015 at 11:45 a.m., indicated "...trays are delivered in closed food carts, or all food and utensils are covered or wrapped...."</p> <p>3.1-21(i)(1)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p>			

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	<p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review the facility's QAA (Quality Assessment and Assurance) Committee failed to identify and implement an action plan for the facility's water temperatures to be maintained within the appropriate guidelines for safe and comfortable water temperatures. This had the potential to affect 7 of 7 residents who reside at the facility.</p> <p>Findings include:</p> <p>The QAA Committee of the CCC (Continuing Care Center, a Skilled Nursing Facility of the Organization) consisted of the DON (Director of Nursing), the Administrator, the Medical Director, the Chief Nursing Officer/Chief Operations Officer of the Organization, the Director of Pharmacy, the Directors of Risk Management, Social Services, Infection Control, the MDS (Minimum Data Set) Coordinator, the Vice President of Quality, the Dietician, Director of Therapies and the Director of Plant Operations (Maintenance). The QAA Committee met quarterly and failed to identify and implement an action plan to maintain safe and comfortable water temperatures for the residents who resided on the CCC Unit.</p>	F 0520	<p>The Director of Nursing is responsible for conducting the quarterly CCC QA meeting. The meeting agenda was revised to include a life safety code report from the Plant Operations Director. The water temperature monitoring report will be a standing agenda item and reported at each meeting from now on. Adverse findings not resolved will be presented to Quality Council by the Director of Nursing with reports forwarded to MEC and Board of Trustees.</p>	07/08/2015			

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	<p>An interview with the DON of CCC and Vice President of Quality for the Organization on 6/19/15 at 11:45 a.m., indicated the QAA Committee met quarterly. She indicated the QAA committee was not aware the CCC Unit's water temperatures were not within an acceptable range for safe and comfortable water temperatures. The DON indicated the Director of Plant Operations, who attended the quarterly QAA meeting, had not reported the hot water temperatures to the QAA Committee. The Vice President of Quality indicated the water temperatures on the CCC unit were to be reported to the CEO of the Origination and would not have been reported to the CCC Units's QAA Committee. The Vice President of Quality also indicated the DON attended the Organization's Quality Council which brought Organization's concerns to the DON's attention.</p> <p>Review of the current facility's policy, titled, Bluffton Regional Medical Center 2015 Quality Improvement Program, with revised date of 2/2015, provided by the DON on 5/15/15 at 3:00 p.m., indicated, "...SAFETY &amp; QUALITY...Patient Safety and Quality: Improving patient safety and proactively identifying and improving systems causes of medical errors....GOALS...To improve</p>			

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	<p>the quality and safety of patient care processes and outcomes....We will promote a non-punitive culture in identification of risks to patient safety....Scope of Activities...The scope of the Organizational Quality Improvement Program encompasses measurement and assessment activities of the Medical Staff, Nursing and Ancillary or support services. Processes and outcomes of care and designed, measured and assessed by appropriate departments...Quality Improvement activities will address both clinical and organizational functions. Theses activities are designed to assess key functions of patient care and to identify, study and correct problems and improvement opportunities found in the processes of care delivery....Reporting...Quality Council reports the identified aspects that require further evaluations, the results of monitoring activities and the improvement action plans as appropriate to the Medical Executive Committee, Administration and Board on at least a quarterly basis....The organization-wide functions shall be measured and assessed in terms of the appropriate dimensions of performance...Safety-the degree to which interventional and environmental risk are minimized for the patient and others, including the health care</p>			

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	<p>provider....Measure...The monitoring and analysis process will included at least the following activities:...Surveillance of Equipment and Utilities Maintenance Programs....Surveillance of Safety and Life Safety Programs...."</p> <p>3.1-52(a)(2)</p>				