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	150075	A. BUILDING 00 B. WING	09/08/2011

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S0000	The visit was for licensure survey. Facility Number: 005069 Survey Date: 09-06-11 to 09-08-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor Lynnette Smith, BS, MLT (ASCP) Medical Surveyor QA: claughlin 09/21/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S0322	410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.			
	Based on document review and interview, the facility failed to maintain its departmental policies/procedures as required by facility policy. Findings: 1. The policy/procedure Hospital Policy Development Guidelines (reviewed 03-21-08) indicated the following: Each department shall...at a minimum of every two (2) years, all department policies will be reviewed, revised, and signed...Signatures must include the department manager...and the department medical director if one exists...[and]...All policies written will adhere to the same formant for consistancy throughout the organization...[and]...All policies will be	S0322	1. and 2. The policy "Hospital Policy Development Guidelines" was reviewed on September 27, 2011 and approved by the CEO on October 3, 2011. The managers were provided an update at the managers meeting on September 28, 2011. Measure to Prevent Reoccurrence: The ACEO will be responsible to monitor compliance with this policy on a monthly basis or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.3. and 4. and 7. The Nuclear Medicine policies and procedures including those from Medical Physicits Consultants (MPC) are being reviewed and formatted to the approved facility format. Index pages will cross reference new policies. The Director of Imaging will have this completed by October 21, 2011. All policies are reviewed annually	10/21/2011

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	formatted in outline style. 2. The policy/procedure Hospital Policy Development Guidelines (reviewed 03-21-08) indicated no review had been performed for more than three years. 3. The nuclear medicine department manual table of contents indicated a numbering system that failed to correspond to the documents contained in the body of the manual. The department policy procedures failed to use the format adopted by the facility in 2008 and none of the policy/procedures were signed and dated as indicated by the administrative policy. Multiple versions of specific policies/procedures (3 versions of Receipt of Packages Containing Radioactive Material) were included in the manual and multiple titles with similar and overlapping content (Ordering and Accepting Delivery of Radioactive Isotopes [and] Procedures for Ordering and Accepting Delivery of Radioactive Material) were identified during the review. 4. The radiology department		by the Medical Director of Imaging.5. and 6. The radiology policy B-13 "Infection Control General Policy" was revised on September 27, 2011 to replace Virex with "hospital approved disinfectant."8. The policy "Drug Therapy Monitoring" was reviewed by the Director of Pharmacy on September 27, 2011. The policy will be presented at the Patient Care meeting on October 13, 2011 for approval.	

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	policy/procedures failed to use the format adopted by the facility in 2008 and none of the policy/procedures were signed and dated as indicated by the administrative policy. 5. The radiology policy/procedure Infection Control General Policy (reviewed 01-11) indicated the following: The table will be cleaned after each patient with Virex disinfectant. Portable unit to be cleaned on 4-12 shift with Virex. 6. During an interview on 09-08-11 at 1355 hours, staff #A3 indicated that the facility had discontinued use of the Virex product in 2010 and was using the 3M product 23H cleaner. 7. During an interview on 09-08-11 at 0830 hours, staff #A14 indicated that the radiology policy/procedures were presently under revision and the nuclear medicine department policy/procedures were going to be re-written to comply with the administrative policy. 8. Review of pharmacy department			

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	policy/procedures indicated many policy/procedures had not been reviewed since 01-09 and the department policy Drug Therapy Monitoring had not been reviewed since 03-08. 9. During an interview on 09-09-11 at 0835 hours, staff #A8 indicated that many policy/procedure updates resulted due to prompting from staff #A7 and the current process was not effective.			
S0332	410 IAC 15-1.4-1(c)(6)(L) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures. Based on review of personnel competency policies, personnel competency documentation, patient records and staff interview, the chief executive officer failed to ensure competency evaluations were documented for the performance of ultrasound therapy for one of one physical	S0332	The rehab associate without the competency for ultrasound therapy was completed on September 30, 2011. The Director of Rehab revised the policy "Competency Protocol" in regard to competency on new equipment. If the vendor is not available a specific process will	09/30/2011

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	therapists. Findings included: 1. Review of personnel competency policies on 9-8-11 between 10:00 AM and 11:15 AM indicated a policy titled: "Competency Protocol", issued on "1/03", which stated: "The extent to which each rehab associate integrates their knowledge...skills...in delivering patient care will be evaluated by use of a skills list..." 2. Review of personnel competency documentation on 9-8-11 between 10:00 AM and 11:15 PM indicated Staff Member #L24 did not have a competency assessment for ultrasound therapy. 3. Review of patient records on 9-8-11 between 12:45 PM and 1:50 PM indicated Staff Member #L24 had performed ultrasound therapy on the following patients, as indicated: Patient Date L21 9-1-11 L22 8-26-11 L23 9-1-11 9-6-11 L24 8-26-11 8-29-11		be developed to include a step by step competency (competency validation checklist) following the instruction manual. A new competency process has been instituted to include a competency validation checklist. The checklist will be established by the therapist that has completed the training that relates to the competency. The Director of Rehab will review the checklist to audit for its entirety and completeness. Measure to Prevent Reoccurrence: The Director of Rehab will be monitor all department competencies on annual basis or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	

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	8-31-11 9-2-11 4. In interview on 9-8-11 between 10:00 AM and 11:15 AM, Staff Members #L10 and L11 acknowledged the above findings.			
S0394	410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 17 contracted services. Findings: 1) On 09-06-11 at 1145 hours, a list of all contracted services was received from staff #A3. The list of services failed to indicate a service provider for an anesthesia machine, biohazardous waste, elevator, exhaust hoods, fire services, generator, laser, laundry, medical transcription, pest control, ventilator, vacuum pump, and xray/CT/MRI machines.	S0394	The Safety Officer has compiled a list of the requested contract services including the scope and nature of the services provided. Measure to Prevent Reoccurence: The Safety Officer will update the list as necessary. The list of contracted services will be a standing agenda item at the Environment of Care meeting. An updated list will be presented to the Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	09/30/2011

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	2. Review of facility documentation indicated the following: anesthesia machine service by #O1 was performed 03-24-11, biohazardous waste was provided by #S1, elevator service was performed by #S2 on 07-08-11, exhaust hoods were inspected by #LTS1 on 04-11, fire service providers included #E1 fire system testing dated 08-09-11, fire panel monitoring by #24M dated 01-11, fire standpipe and sprinkler control valve service by #S3 dated 08-29-11 and fire extinguisher service by #FPS1, generator service by #M1 dated 02-11, laser service by #FM1 dated 03-17-11, laundry service by #HLS1, medical transcription by #M2, pest control by #M3 dated 08-17-11, ventilator service by #ABE1 dated 03-29-11, vacuum pump service by #BM1 dated 03-11-11, xray/CT/MRI/Gamma Camera service by #P1 dated 03-25-11 and radiation badge testing by #MT1 dated 05-11-11. 3. On 09-08-11 at 0900 hours, staff #A3 confirmed the list of contracted services failed to include the providers identified through facility documentation.			
S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and interview, the facility failed to ensure patient safety by not assuring that outdated/expired items were taken out of stock for use in the facility. Findings included:	S0554	All expired items removed during the survey. Measure to Prevent Reoccurrence: On the first working day of each month, a surgery staff member will be assigned to remove all outdated/expired items from	10/03/2011

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	1. During a tour of the Surgery department on 9/8/2011, the following were found in Operating Suite #2: one box of 10 "J" cannula Surgical instruments with an expiration date of 8/2011 and 7 Alcon cataract implants with an expiration date of 8/2011. 2. At time of observation, E#1 verified that the items were expired. 3. E#1 stated there is no checklist for the items in the OR suites and there is no hospital policy regarding checking for expired items. Their practice is to check items monthly.		stock. The Surgical Services Coordinator will be responsible to monitor the process for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	
S0606	410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on policy and procedure review, personnel file review, and staff interview, the infection control committee failed to ensure an active, effective program was in place related to communicable disease	S0606	Effective October 9, 2011 Business Health Services will offer the appropriate vaccine for any equivocal or non-immune lab results on new hires. The policy IC 06 "Personnel Immunization"	10/09/2011

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	history for 1 of 4 RN (registered nurse) employee files reviewed (P4). Findings: 1. at 11:40 AM on 9/8/11, review of personnel files indicated: a. staff member P4 was hired 8/29/10 and had a rubella titer result of "5" dated as "collected" on 8/30/10 and "verified" on 9/1/10 b. the 9/1/10 lab document indicated a titer result of 5 to 9 was "Equivocal", or unknown immunity c. a hand written note on the lab report reads: "documented immunity to rubella 5/14/10 from [another acute care hospital] Equivocal results 8/30/10 no action needed." 2. at 2:20 PM on 9/8/11, review of the policy and procedure "Personnel Immunization", IC 06, reads under "Responsibilities": a. "...2. [the facility] will provide the following immunization to regular associates who are not immune to: A. Rubella...3. Business Health Services will assess immune status at the time of hiring..." 3. interview with staff member NI at 2:05 PM indicated: a. the 5/14/10 rubella titer result from another facility should not have been		has been revised to address equivocal status results for titers.The associate P4 was hired on 8/29/10 and had a "documented immunity to reubella 5/14/10 from (another acute care hospital). Equivocal results 8/30/10 no action needed." This associate is no longer employed with Bluffton Regional Medical Center.Measure to Prevent Reoccurrence: The Manager of Business Health will monitor new hires for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	

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	accepted when this facility's lab result was equivocal b. staff member P4 should have had follow up (with an offer of immunization) to the equivocal titer result for Rubella in August/September of 2010 c the current policy does not address equivocal status results for titers			
S0712	410 IAC 15-1.5-4 (c)(1) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information. Based on policy and procedure review, committee meeting agenda review, patient medical record review and staff interview, the facility failed to ensure accuracy in the medical record for 3 of 18 records reviewed (N1, N2 and N3) and failed to ensure that only approved abbreviations were used for 1 medical record (N14). Findings: 1. at 11:15 AM on 9/8/11, review of the policy and procedure "HI 04", "Medical Record Entries", indicated:	S0712	Response to items 1, 2, 3 and 4dThis deficiency has been corrected by reviewing the deficiency with the OB/Peds Committee on September 27, 2011 and Medical Executive Committee on September 28, 2011. The policy on Medical Records Entries HI 04 was also reviewed. The practitioners were informed of the unapproved abbreviations and were instructed on the approved resource for approved abbreviations.Measure to Prevent Reoccurrence: The Director of Women's Center will	09/30/2011

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	a. under "Purpose", it read: "All entries within the patient's health information record (medical record) must be accurate,..." 2. at 10:45 AM on 9/8/11, review of the patient care review committee meeting agenda for June 10, 2010 indicated: a. abbreviations were approved at this meeting (and did not include UOP) 3. at 10:05 AM on 9/8/11, review of the Medical Staff policy (rule/regulation) MS10-97-2, "General Policies for Health Information Records", indicated: a. under "General Instructions", in item 11., it read: "Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Health Information Management Department..." 4. review of patient medical records through out the survey process of 9/6/11 to 9/8/11 indicated: a. pt. N1: A. had documentation on the "Patient Registration Form" and in the "Nursing Information Assessment" tool that indicated the patient had executed an advance directive B. had documentation on the "Inpatient/Outpatient Conditions of		monitor OB records for six months or until 100% compliance is met. Findings will be reported to Quality Council and forwarded to Medical Executive Committee and Board of Trustees.Response to items 4c and 5bEffective September 28, 2011, the orders for Versed in endoscopy will be written for each dose as ordered to prevent documentation discrepancy.Measure to Prevent Reoccurrence: The Surgical Services Coordinator will conduct a chart audit for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.Response to items 4a and 4bTo eliminate inaccuracy within the medical record resulting from multiple queries pertaining to the subject of advance directives, advance directives will be addressed at Registration and noted on the "Inpatient/Outpatient Conditions of Admission" form. Additional information on advance directives will be offered at that time. Automatic recall for advance directives will be removed from the "Patient Registration" form. The Director of Patient Accounts is responsible for the change to the form and education of registration staff. Queries regarding advance directives will be removed from nursing admission tool by the Nursing IT	

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	Admission..." form that the patient stated "I have not executed any advanced directives..," b. pt. N2: A. had documentation on the "Patient Registration Form" indicating the patient did not have an advance directive B. had documentation in the "Nursing Information Assessment" tool that indicated the patient did have an advance directive c. pt. N3 had: A. documentation by the physician, in the dictated Colonoscopy report, that the patient had 10 mg of Versed during the procedure B. documentation in the electronic procedure report that the patient had 10 mg of Versed during the procedure C. had an order for "Versed 10 mg Intravenous times 1" on the "routine Endoscopy Orders" form D. documentation by nursing, in the intraoperative area of the record, that 9 mg of Versed were administered in 3 separate portions of 3 mg., 2 mg., 2 mg., and another 2 mg d. pt. N14 had documentation in the medical record (in the "notes" section of the "Discharge Assessment" form on pg. 2 of 2) that read: "BF (breast fed) X 9 UOP		Liaison. Nursing will continue to screen for concerns regarding advance directives. Nursing will notify case management if follow up is indicated.	

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	(urinary output) X 1" and "BM (bowel movement) X 1 UOP X 2 since delivery" 5. interview with staff member NI at 10:30 AM on 9/8/11 indicated: a. patients N1 and N2 had conflicting information in the medical record related to whether or not the patients had executed advance directives b. pt. N3 had inaccurate information related to the amount of Versed given during their endocscopy procedure c. the abbreviation UOP is not a facility approved abbreviation			
S0744	410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on policy and procedure review, patient medical record review and staff interview, the facility failed to ensure that medical records were complete for 5 of 18 patient records reviewed (pts. N2, N12, N14, N15, and N18). Findings: 1. at 11:15 AM on 9/8/11, review of the policy and procedure "HI 04", "Medical Record Entries", indicated:	S0744	2. To eliminate inaccuracy within the medical record resulting from multiple queries pertaining to the subject of advance directives, advance directives will be addressed at Registration and noted on the "Inpatient/Outpatient Conditions of Admission" form. Additional information on advance directives will be offered at that time. Automatic recall for advance directives will be removed from the "Patient Registration" form. The Director	10/14/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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. under "Purpose", it read: "All entries within the patient's health information record (medical record) must be accurate, legible, dated, timed, and authenticated..." 2. review of patient medical records through out the survey process of 9/6/11 to 9/8/11 indicated: a. pt. N2 lacked documentation by nursing on the "Nursing Information Assessment" tool in relation to the question "When can you get a copy for your chart"--when the patient reported having a Living Will that needed to be provided to the facility for inclusion in the medical record b. pt. N12 was lacking completion by nursing in the advanced directives section of the "Nursing Information Assessment" area of the electronic medical record for the questions: "Would you like more information on Advanced Directives"; "Brochure given to patient"; and "If not competent was information given to family member" c. pt. N14 lacked documentation of the time of the circumcision in the "procedure/labs" section of the "discharge assessment" form d. pt. N15 lacked completion of the "Procedure Record" form in the "Diagnosis" and "Referring Physician" areas in the top left portion of the form e. pt. N18 lacked completion at the		of Patient Accounts is responsible for the change to the form and education of registration staff. Queries regarding advance directives will be removed from nursing admission tool by the Nursing IT Liaison. Nursing will continue to screen for concerns regarding advance directives. Nursing will notify case management if follow up is indicated. 1. and 3. The scope and purpose of policy HI 04 "Medical Record Entries" was revised to include reference to all categories of individuals who are allowed to make entries in the medical record. The policy was also revised so that blanks in medical record forms are completed by all staff responsible for entries.Measure to Prevent Reoccurrence: Review the revised policy at the Management Meeting on October 12, 2011 and at the Patient Care Review Committee on October 13, 2011. The HIM Director will audit for blanks in record forms for six months or until 100% compliance is met. Findings will be reported to Quality Council and forwarded to Medical Executive Committee and Board of Trustees.	

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	150075	A. BUILDING 00 B. WING	09/08/2011

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	bottom of the "Obstetric Discharge Record" form related to the "Newborn Status" upon discharge, and "Maternal Disposition and condition on discharge" and the "date and time" of discharge 3. interview with staff member NI at 10:00 AM on 9/8/11 indicated: a. documentation was missing, as stated in 2. a., b., c., and d. above b. pt. N18 had some, but not all, of the required discharge information (from the bottom of the "Obstetric Discharge Record" form) noted in the physician's progress notes c. the bottom portion of the "Obstetric Discharge Record" form should have been completed at the time of the patient's discharge d. there is no facility policy that addresses completeness of the medical record, except for physician reports that need to be completed "without blanks" prior to the physician authentication of the report (policy HI 04, as listed in 1. above)			
S0748	410 IAC 15-1.5-4 (e)(3) (e) All entries in the medical record shall be: (3) authenticated and dated promptly in accordance with subsection (c)(3).			

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	Based on policy and procedure review, patient medical record review and staff interview, the facility failed to ensure the authentication of entries in the medical record, per policy, in 4 of 18 records reviewed. (N1, N4, N9 and N17) Findings: 1. at 11:15 AM on 9/8/11, review of the policy and procedure "HI 04", "Medical Record Entries", indicated: a. under "Purpose", it read: "All entries within the patient's health information record (medical record) must be accurate, legible, dated, timed, and authenticated..." 2. review of patient medical records through out the survey process of 9/6/11 to 9/8/11 indicated: a. pts. N1 and N17 lacked a time of authentication on the "Inpatient/Outpatient Conditions of Admission..." form by both the patient and the witness b. pts. N4 and N9 lacked a date and time of authentication on the "Inpatient/Outpatient Conditions of Admission..." form by the patient and lacked a witness signature in relation to the signing by the patient 3. interview with staff member NI at 10:00 AM on 9/8/11 indicated that the medical records, as listed in 2 above, were	S0748	On October 11, 2011 the Registration Manager will educate registration staff on "HI04" regarding the requirement for a witness signature, date and time on the "Inpatient/Outpatient Conditions of Admission." On October 18, 2011 the Director of Women's Center will educate OB nursing staff on "HI04" regarding the requirement for a witness signature, date and time on the "Inpatient/Outpatient Conditions of Admission."Measure to Prevent Reoccurrence: The Registration Manager will conduct an audit of the Inpatient/Outpatient Conditions of Admission forms in OB for witness signature, date and time for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	10/18/2011

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	lacking dating and/or timing of patient signatures on the consent to admit and treat form, and were lacking witness authentication for pts. N4 and N9			
S0751	410 IAC 15-1.5-4(f)(2) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (2) The medical history and physical examination of the patient done within the time frames as prescribed by the medical staff rules and section 5 (b)(3)(M) of this rule. Based on review of medical staff rules and regulations, policy and procedure review, patient medical record review and staff interview, the facility failed to ensure the completion of a medical history and physical for 1 of 2 OB (obstetric) patients (pt. N4). Findings: 1. at 10:05 AM on 9/8/11, review of the Medical Staff policy (rule/regulation) MS10-97-2, "General Policies for Health Information Records", indicated: a. under "General Instructions", in item 10., it read: "The current obstetrical record shall include a complete prenatal record. The prenatal record may be a	S0751	This deficiency has been corrected by revising Medical Staff Policy MS-10-97-2 "General Policies for Health Information Records." This policy is now consistent with Policy HI 16 "History and Physical Content Management." The prenatal record and a progress note by the practitioner serves as a history and physical for an OB admission. Measures to Prevent Reoccurrence: On September 27, 2011 the required content of an OB admission history and physical was discussed at the OB/Peds Committee meeting. The Director of Women's Center will monitor OB records for a complete admission history and physical for six months or until 100% compliance is met.	09/28/2011

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	legible copy of the attending Practitioner's office record transferred to the Hospital before admission, but Obstetric Admitting Record form must be filled out completely on all obstetrical delivery admissions..." 2. at 10:30 AM on 9/8/11 review of the policy HI 16, "History and Physical Content Management", indicated: a. under "Policy", in item number 9., it read: "Obstetrical Cases A copy of the prenatal H&P, completed at the initiation of prenatal care, along with continuing progress notes describing the course of prenatal care, may serve as the H&P for patients admitted to Obstetrics. An appropriate physical assessment shall be completed and recorded in the admission progress note to update the prenatal H&P." 3. at 8:30 AM on 9/7/11, review of patient medical records indicated pt. N4: a. was a prenatal admitted to the OB unit on 4/10/11 and had a prenatal history and physical record from the physician's office with a last visit date of 2/23/11 b. had a "Labor Progress" note written by the physician on the "Progress Notes" at 7:50 PM on 4/10/11 c. had a "Delivery Note" written on 4/10/11 at 8:30 PM by the physician on the "Progress Notes"		Findings will be reported to Quality Council and forwarded to Medical Executive Committee and Board of Trustees.	

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	4. interview with staff member NI at 10:00 AM on 9/8/11 indicated: a. the medical staff policy, MS10-97-2, and the health information management policy, HI 16, do not agree on what is expected regarding an OB admission H & P b. the medical record for pt. N4 was lacking an OB admission H & P in relation to either policy and procedure (as listed in 1. and 2. above) as there is no admission note that contains a physical assessment that follows the requirements of the medical staff in relation to all of the components required for a complete physical examination, nor is there an "Obstetricl Admitting Record" form as required by policy MS10-97-2			
S0870	410 IAC 15-1.5-5(b)(3)(N) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies. Based on policy and procedure review,	S0870	On September 13, 2011 the	09/15/2011

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	patient medical record review and staff interview, the physician failed to provide an order for medication that was administered to 1 of 2 OB (obstetric) patients (pt. N18). Findings: 1. at 9:30 AM on 9/8/11, review of the policy and procedure "Dispensing - General", MM23, indicated: a. on page 2 under "Requirement for an Original or Direct Copy of a Medication Order"..."Medications may be dispensed only from the original or a direct copy of the prescriber's medication order..." 2. at 4:45 PM on 9/7/11, review of patient medical record N18 indicated: a. the patient was administered Cytotec 25 mg with documentation by the physician in the progress notes at 8:15 AM on 7/22/11 b. the patient was administered Cytotec 25 mg with documentation by the physician in the progress notes at 12:10 PM on 7/22/11 c. the patient only had an order for the 8:15 AM Cytotec 3. interview with staff member NI at 10:00 AM on 9/8/11 indicated: a. a second order for the Cytotec given to pt. N18 at 12:10 PM on 7/22/11 could not be found in the patient's medical		Director of Women's Center educated the OB staff on the proper process to access Cytotec from Pyxis so as to prevent the missing of an order. On September 15, 2011 the Director of Pharmacy educated the pharmacy staff on the proper process that nursing utilizes to access Cytotec from Pyxis.Measure to Prevent Reoccurrence: The Director of Pharmacy will monitor orders for Cytotec for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	

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	record b. there should have been an order written for the Cytotec given at 12:10 PM on 7/22/11			
S0912	410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.			

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	Based on policy and procedure review, patient medical record review and staff interview, the nursing executive failed to implement the transfer policy for 1 of 2 transferred patients (pt. N9) and failed to ensure the implementation of physician orders for 2 of 2 endoscopy patients (N3 and N15). Findings: 1. at 3:55 PM on 9/7/11, review of the policy PC 25, "Transfer of Patients", indicated: a. under "Responsibilities", it read in item 3. "Transfer to another hospital...: the patient transfer from should be completed by the RN and the physician. The patient transfer form should be made in duplicate. The copy is to remain with the patient's chart..." 2. review of pt. N9's chart on 9/7/11 indicated: a. the newborn was transferred to a neonatal specialty hospital directly after birth (other facility neonatal staff were on hand for the delivery) b. the medical record is lacking a transfer form c. there was no physician order obtained to transfer the patient 3. review of patient medical records N3 and N15 on 9/7/11 and 9/8/11 indicated:	S0912	1. and 2. and 4. On September 13, 2011 the Director of Women's Center reviewed policy PC 25 "Transfer of Patients" including appropriate transfer documentation and physicians orders with staff. On September 27, 2011 the Interim Director Quality Management and Regulatory Compliance reviewed the policy with the physicians at the OB/Peds meeting.Measure to Prevent Reoccurrence: The Director of Women's Center will conduct monthly audits on all inpatient transfers from the women's center for appropriate documentation and orders for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.3. As of October 1, 2011 the endoscopy post procedure order sheet has been revised to read:"Nothing by mouth x_____minutes following last medication dose." Measure to Prevent Reoccurrence: The Surgical Services Director will conduct monthly audits on endoscopy patients for following the order as written for six months or until 100% compliance is met. Findings will be presented to Quality Council with reports forwarded to Medical Executive Committee and Board of Trustees.	10/01/2011

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	a. pt. N3 had: A. a post procedure order: "...nothing by mouth x 30 minutes" written by the physician B. was documented as having arrived in the PACU (post anesthesia care unit) at 9:15 AM C. was noted as "Drinking soda" at 9:30 AM b. pt. N15 had: A. a post procedure order: "...nothing by mouth x 60 minutes" written by the physician B. was documented as having arrived in the PACU at 2:00 PM C. was noted as "Pt. drinking sprite" at 2:45 PM 4. interview with staff member NI at 4:00 PM on 9/7/11 indicated: a. the medical record for pt. N9 was lacking both a transfer form and an order for transfer b. the transfer policy does not address the need for a physician order to transfer a patient c. nursing staff documented the offering of liquids to endoscopy patients before the ordered time had elapsed			

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S1232	410 IAC 15-1.5-9(c) (c) Procedures and treatments are performed on the written request of individuals and practitioners allowed to order such procedures and treatments and receive the results of the evaluations to the extent permitted by law and authorized by the governing body. Based on document review and interview, the facility lacked a policy/procedure indicating only practitioners with clinical privileges may order radiologic procedures and treatments unless authorized by the governing board for the facility. Findings: 1. The radiology policy/procedure E-06 Outpatient Orders (reviewed 01-11) indicated the following: Outpatient imaging procedures will be completed with the proper documentation and authorization. Any outpatient reporting to Bluffton Regional Medical center for imaging studies will be required to present an order that requires the following: Patient name, examination requested, indication for the examination, and signature by the physician. 2. The radiology policy/procedure E-04 report Distribution (reviewed 01-11)	S1232	Imaging policies E-04 and E-06 have been revised reflecting revisions to policy HI 04 defining outpatient requirements for outside practitioners without privileges (ancillary services) for making entries into the medical record, i.e. ordering tests.	09/28/2011

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	indicated the following: Outside ordering physicians will have their reports faxed to them upon signing. 3. On 09-06-11 at 0930 hours, staff #A2 was requested to provide the department policy/procedure indicating only practitioners with clinical privileges may order radiologic procedures and treatments unless authorized by the governing board for the facility and no documentation was provided prior to exit. 4. On 09-08-11 at 1000 hours, staff #A3 was requested to provide a policy/procedure indicating only practitioners with clinical privileges may order radiologic procedures and treatments unless authorized by the governing board for the facility and no documentation was provided prior to exit. 5. On 09-08-11 at 1210 hours, staff #A3 confirmed that no provision for ordering radiologic tests by practitioners without clinical privileges was indicated in the medical staff bylaws, rules and regulations.			

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S1608	410 IAC 15-1.6-3 (b)(1) (b) Radioactive materials shall be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice, and federal and state law, as follows: (1) In-house preparations of radio-pharmaceuticals is by, or under, the direct supervision of an appropriately trained registered pharmacist or physician. Based on document review and interview, the nuclear medicine department failed to maintain its policies/procedures for safely receiving and opening packages containing radioactive materials. Findings: 1. The Nuclear Medicine policy/procedures manual indicated the following: Three versions of the policy/procedure Receipt of Packages Containing Radioactive Material lacking identical content, Two versions of the policy/procedure Ordering and Accepting Delivery of Radioactive Isotopes without identical content, the policy/procedure Procedures for Ordering and Accepting Delivery of Radioactive Material, two versions of the policy/procedure	S1608	The Nuclear Medicine policies and procedures including those from Medical Physicits Consultants (MPC) are being reviewed and formatted to the approved facility format. Index pages will cross reference new policies. The Director of Imaging will have this completed by October 21, 2011. All policies are reviewed annually by the Medical Director of Imaging.	10/21/2011

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	Procedures for Safely Opening Packages Containing Radioactive Material with different content, and the policy/procedure Receiving Radionuclides. It could not be determined which policy/procedure would be followed by department staff. 2. During an interview on 09-08-11 at 0830 hours, staff #A14 indicated the nuclear medicine department policy/procedures are going to be re-written to comply with the administrative policy.			