| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 151304 | A. BUILDING 00<br>B. WING | 04/07/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RUSH MEMORIAL HOSPITAL | 1300 N MAIN ST<br>RUSHVILLE, IN 46173 |

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| C 0000<br><br>Bldg. 00 | The visit was for investigation of a Federal Critical Access Hospital (CAH) complaint.<br><br>Complaint Number: IN00326370<br><br>Substantiated: Deficiencies related to the allegations are cited. Unrelated deficiencies cited.<br><br>Survey Date: 04/6-7/2021<br><br>Facility Number: 005082<br><br>QA: 04/16/2021 | C 0000 | | |
| C 0336<br><br>Bldg. 00 | 485.641(b)<br>QUALITY ASSURANCE<br>The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that --<br>Based on document review and interview, the facility failed to follow its Medical Staff Bylaws and its Quality Assurance and Improvement (QAPI) plan and ensure all patient records meeting surgery and anesthesia department review triggers were identified and reviewed for one occurrence (Patient #1).<br><br>Findings include:<br><br>1. Review of the Quality Assurance and Improvement (QAPI) Plan (approved 11-19) indicated the following: "The Board delegates the responsibility for implementing this QAPI Plan to | C 0336 | 1. Reviewed and updated the current Medical Staff Quality Measures Monitored by Quality Department<br>2. Reminder to all directors of what triggers a peer review in their department. Surgery staff reeducated on peer review triggers<br>3. Guidelines will be reviewed by quality department as needed and updated if indicated.<br>4. Peer review will continued to be reported in quarterly QI meetings<br>5. Medical Staff coordinator will | 05/10/2021 |

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

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| | the medical staff, the hospital's leadership team and the Quality Improvement Committee."<br><br>2. Review of the Medical Staff Bylaws (approved 1-15) indicated the following: "Article XII: Committees... 12-1-3 Quality and appropriateness of care/morbidity... (c)... establish and utilize objective criteria in the collection and assessment of information; and (d) document the findings from the monitoring, assessment, and problem-solving activities, and the action taken to resolve problems and improve patient care."<br><br>3. Review of the document Medical Staff Quality Measures Monitored by Quality Department (no review date) indicated the following: "(b) Surgery and Anesthesia Department Review Triggers... Patient transfer to another facility during perioperative period..."<br><br>4. Review of the medical record (MR) for Patient #1 indicated on 12-23-16 the surgical patient experienced respiratory failure during the immediate post-operative period and was transferred to another hospital for ongoing care.<br><br>5. On 4-7-21 at 1300 hours, the Vice President of Nursing A2 was requested to provide any QAPI or Medical Staff documentation indicating a surgery and anesthesia department review was performed for any of the MRs sampled to review and none was provided prior to exit.<br><br>6. On 4-7-21 at 1500 hours, the Safety, Compliance and Risk Manager A4 confirmed the facility lacked documentation indicating a surgery and anesthesia department review was conducted in 2017 for the indicated MR and confirmed no other documentation was available. | | be responsible for maintaining documentation related to peer review process | |

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| C 1110<br><br>Bldg. 00 | 485.638(a)(4)(i)<br>RECORDS SYSTEM<br>For each patient receiving health care services, the CAH maintains a record that includes, as applicable--<br><br>(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;<br>Based on document review and interview, the facility failed to ensure an informed consent was documented in the medical record for 1 of 10 surgical records reviewed (Patient #1).<br><br>Findings include:<br><br>1. Review of the policy/procedure Transfer of a Patient to Another Acute Care Facility (reviewed 12-15) indicated the following: "Patients requiring transfer should have the risks and benefits of transfer explained to him/her or his/her appointed guardian, representative, or next of kin prior to transfer. Patient consent to transfer should be obtained prior to transfer..."<br><br>2. Review of the MR for Patient #1 indicated the Orthopedic Surgeon MD13 discussed the need to transfer the post-operative patient to another hospital with the patient's spouse and family member FM31 and lacked documentation indicating written and/or verbal consent for the patient transfer was obtained from the patient or the patient's representative FM31.<br><br>3. On 4-6-21 at 1500 hours, the Vice President of Nursing A2 confirmed the MR for Patient #1 lacked the above. | C 1110 | 1. Policy and procedure on transfer of a patient to another acute care facility, that included informed consent was reviewed by VP of Nursing and Surgery Director. No updates needed but education on transfer and informed consent will be given to all surgery staff.<br>2. Surgery Director will add transfer training/informed consent to yearly competency for all surgery staff members .Surgery Director will do audits on all surgery patients transfer charts to make sure chart is complete and accurate and have informed consent documented either verbally or written. Any deficit in documentation by staff will be reeducated by Surgery Director.<br>3. Policy and Procedure is reviewed every year by Surgery director and all staff<br>4. Surgery director is responsible for making sure policy and procedure is followed accurately and competency are done | 05/10/2021 |

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| | | | yearly | |
| C 1114<br>Bldg. 00 | 485.638(a)(4)(ii)<br>RECORDS SYSTEM<br>Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;<br>Based on document review and interview, the facility failed to ensure a history and physical (H&P) examination was present in the medical record (MR) prior to surgery for 1 of 10 surgical records reviewed (Patient #10).<br><br>Findings include:<br><br>1. Review of the Medical Staff Rules and Regulations (approved 1-15) indicated the following: "A medical record shall be considered incomplete if it needs any of the following...b. History and Physical...[and]... A surgical patient's chart must include: Complete history and physical exam prior to surgery..."<br><br>2. Review of the MR for Patient #10 indicated the patient was admitted on 12-23-16 to the outpatient surgery unit for a left shoulder arthroscopy and rotator cuff repair procedure and lacked documentation indicating a H&P was present in the MR.<br><br>3. On 4-7-21 at 1538 hours, staff A5 confirmed the MR for Patient #10 lacked the above. | C 1114 | 1. Surgery Encounter Analysis Policy and Procedure were reviewed and updated by Surgery Director and approved by VP of Nursing<br>2. Surgery Director will doing yearly education with all surgery staff members on Surgery Encounter Analysis Policy and Procedure. Surgery Director will do random audits on surgery encounters to assure completion. Reeducation and accountability by Surgery Director to staff members who do not following the policy and procedure correctly.<br>3. Policy and Procedure is reviewed every year by Surgery Director and staff<br>4. Surgery director is responsible for making sure policy and procedure is followed accurately | 05/10/2021 |
| C 1430<br>Bldg. 00 | 485.642(b)<br>DISCHARGE PLANNING<br>(b) Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. The CAH must discharge the patient, and also transfer or refer the patient where applicable, along | | | |

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| | with all necessary medical information pertaining to the patient's current course of illness and treatment, postdischarge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.<br>Based upon document review and interview, the facility failed to follow its policies and procedures and ensure that copies of medical records (MR) were sent with the transfer patient to the receiving facility for 1 of 10 MR reviewed (Patient #1).<br><br>Findings include:<br><br>1. Review of the policy/procedure Transfer of a Patient to Another Acute Care Facility (reviewed 12-15) indicated the following: "The following information should be sent with the patient and communicated with the receiving facility... Patient name...vital signs... medications administered... History and Physical... reason for transfer... nursing notes... all tests and procedures performed..."<br><br>2. Review of the MR for Patient #1 indicated the post-operative patient was transferred to another hospital for ongoing care and lacked documentation indicating the copies of the MR that were available at the time of transfer and sent with the patient to the receiving facility.<br><br>3. On 4-6-21 at 1500 hours, the Vice President of Nursing A2 confirmed the above. | C 1430 | 1. Policy and procedure on transfer of a patient to another acute care facility, that included copies of MR being sent was reviewed by VP of Nursing and Surgery Director. No updates needed but education on transfer and sending MR will be given to all surgery staff by the Surgery Director<br>2. Surgery Director will add transfer training/sending MR to yearly competency for all surgery staff members .Surgery Director will do audits on all surgery patients charts to make sure chart is complete and accurate and have sending MR . Any deficit in documentation by staff will be reeducated by Surgery Director.<br>3. Policy and Procedure is reviewed every year by director and all staff<br>4. Surgery director is responsible for making sure policy and procedure is followed accurately and competency are done yearly | 05/10/2021 |
| S 0000 | | | | |

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| Bldg. 00 | The visit was for investigation of a State licensure hospital complaint.<br><br>Complaint Number: IN00326370<br><br>Substantiated: Deficiencies related to the allegations are cited. Unrelated deficiencies cited.<br><br>Survey DateS: 04/6-7/2021<br><br>Facility Number: 005082<br><br>QA: 04/16/2021 | S 0000 | | |
| S 0416<br><br>Bldg. 00 | 410 IAC 15-1.4-2<br>QUALITY ASSESSMENT AND IMPROVEMENT<br>410 IAC 15-1.4-2(a)(3)<br><br>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:<br><br>(3) All medical and surgical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes.<br>Based on document review and interview, the facility failed to follow its Medical Staff Bylaws and its Quality Assurance and Improvement | S 0416 | 1. Reviewed and updated the current Medical Staff Quality Measures Monitored by Quality | 05/10/2021 |

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| | (QAPI) plan and ensure all patient records meeting surgery and anesthesia department review triggers were identified and reviewed for one occurrence (Patient #1).<br><br>Findings include:<br><br>1. Review of the Quality Assurance and Improvement (QAPI) Plan (approved 11-19) indicated the following: "The Board delegates the responsibility for implementing this QAPI Plan to the medical staff, the hospital's leadership team and the Quality Improvement Committee."<br><br>2. Review of the Medical Staff Bylaws (approved 1-15) indicated the following: "Article XII: Committees... 12-1-3 Quality and appropriateness of care/morbidity... (c)... establish and utilize objective criteria in the collection and assessment of information; and (d) document the findings from the monitoring, assessment, and problem-solving activities, and the action taken to resolve problems and improve patient care."<br><br>3. Review of the document Medical Staff Quality Measures Monitored by Quality Department (no review date) indicated the following: "(b) Surgery and Anesthesia Department Review Triggers... Patient transfer to another facility during perioperative period..."<br><br>4. Review of the medical record (MR) for Patient #1 indicated on 12-23-16 the surgical patient experienced respiratory failure during the immediate post-operative period and was transferred to another hospital for ongoing care.<br><br>5. On 4-7-21 at 1300 hours, the Vice President of Nursing A2 was requested to provide any QAPI or Medical Staff documentation indicating a | | Department<br>2. Reminder to all directors of what triggers a peer review in their department. Surgery staff reeducated on peer review triggers<br>3. Guidelines will be reviewed by quality department as needed and updated if indicated.<br>4. Peer review will continued to be reported in quarterly QI meetings<br>5. Medical Staff coordinator will be responsible for maintaining documentation related to peer review process | |

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| | surgery and anesthesia department review was performed for any of the MRs sampled to review and none was provided prior to exit.<br><br>6. On 4-7-21 at 1500 hours, the Safety, Compliance and Risk Manager A4 confirmed the facility lacked documentation indicating a surgery and anesthesia department review was conducted in 2017 for the indicated MR and confirmed no other documentation was available. | | | |
| S 1318<br><br>Bldg. 00 | 410 IAC 15-1.5-10<br>UTILIZATION REVIEW & DISCHARGE PLANNING<br>410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)<br><br>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:<br><br>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following:<br>(A) medical history;<br>(B) current medications;<br>(C) activities status;<br>(D) nutritional needs;<br>(E) outpatient service needs;<br>(F) follow-up care needs; and<br>Based upon document review and interview, the facility failed to follow its policies and procedures and ensure that copies of medical records (MR) | S 1318 | 1. Policy and procedure on transfer of a patient to another acute care facility, that included | 05/10/2021 |

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| | were sent with the transfer patient to the receiving facility for 1 of 10 MR reviewed (Patient #1).<br><br>Findings include:<br><br>1. Review of the policy/procedure Transfer of a Patient to Another Acute Care Facility (reviewed 12-15) indicated the following: "The following information should be sent with the patient and communicated with the receiving facility... Patient name...vital signs... medications administered... History and Physical... reason for transfer... nursing notes... all tests and procedures performed..."<br><br>2. Review of the MR for Patient #1 indicated the post-operative patient was transferred to another hospital for ongoing care and lacked documentation indicating the copies of the MR that were available at the time of transfer and sent with the patient to the receiving facility.<br><br>3. On 4-6-21 at 1500 hours, the Vice President of Nursing A2 confirmed the above. | | copies of MR being sent was reviewed by VP of Nursing and Surgery Director. No updates needed but education on transfer and sending MR will be given to all surgery staff by the Surgery Director<br>2. Surgery Director will add transfer training/sending MR to yearly competency for all surgery staff members .Surgery Director will do audits on all surgery patients charts to make sure chart is complete and accurate and have sending MR . Any deficit in documentation by staff will be reeducated by Surgery Director.<br>3. Policy and Procedure is reviewed every year by director and all staff<br>4. Surgery director is responsible for making sure policy and procedure is followed accurately and competency are done yearly | |
| S 2120<br><br>Bldg. 00 | 410 IAC 15-1.6-8<br>SURGICAL SERVICES<br>410 IAC 15-1.6-8 (c)(2)<br><br>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:<br><br>(2) There shall be a history and physical workup in the chart of every patient prior to surgery, except in emergencies. If this has been | | | |

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| | dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting physician, which includes vital signs, allergies, and appropriate data.<br>Based on document review and interview, the facility failed to ensure a history and physical (H&P) examination was present in the medical record (MR) prior to surgery for 1 of 10 surgical records reviewed (Patient #10).<br><br>Findings include:<br><br>1. Review of the Medical Staff Rules and Regulations (approved 1-15) indicated the following: "A medical record shall be considered incomplete if it needs any of the following...b. History and Physical...[and]... A surgical patient's chart must include: Complete history and physical exam prior to surgery..."<br><br>2. Review of the MR for Patient #10 indicated the patient was admitted on 12-23-16 to the outpatient surgery unit for a left shoulder arthroscopy and rotator cuff repair procedure and lacked documentation indicating a H&P was present in the MR.<br><br>3. On 4-7-21 at 1538 hours, staff A5 confirmed the MR for Patient #10 lacked the above. | S 2120 | 1. Surgery Encounter Analysis Policy and Procedure were reviewed and updated by Surgery Director and approved by VP of Nursing<br>2. Surgery Director will doing yearly education with all surgery staff members on Surgery Encounter Analysis Policy and Procedure. Surgery Director will do random audits on surgery encounters to assure completion. Reeducation and accountability by Surgery Director to staff members who do not following the policy and procedure correctly.<br>3. Policy and Procedure is reviewed every year by Surgery Director and staff<br>4. Surgery director is responsible for making sure policy and procedure is followed accurately | 05/10/2021 |