This visit was for a standard licensure survey.

Facility Number: 004718

Survey Date: 04-11/13-2016

QA: cj05/24/16

IDR Committe Held on 07-27-16. Tag S01186 modified. JL

Based on document review and interview, the governing board failed to review reports of quality activities for 1 directly-provided services and 1 other activity for calendar year 2015.

1. The Hospital Performance Improvement Plan was revised to include monitoring and reporting for Outpatient Psychiatry (Behavioral Health). This monitor will be reported through the

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.
Findings include:

1. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the directly-provided service of outpatient psychiatry and the activity of reportable events.

2. Interview of employee #A1, Quality Services Director, on 04-12-2016 at 12:25 pm, confirmed all the above and no further documentation was provided prior to exit.

   *established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached.
   *The Annual Patient Safety Summary Report was revised to include activity of reportable events. The Annual Patient Safety Summary Report will be reported through the established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached.
   *A cross reference of the QAPI Monitor List provided by the Indiana State Department of Health Surveyors at the time of survey to the Organization PI Plan was conducted to assure all applicable services, including Outpatient Psychiatry (Behavioral Health), is part of the hospital's QAPI program. Supporting documentation is attached. The Performance Improvement Organizational Reporting & Communication (Appendix A) of Performance Improvement Plan was revised to include Reportable Events. Supporting documentation is attached.
   *Margaret Mary Health's Department Managers were reminded that any new services, including contracted services, are part of the hospital's QAPI program. A template was developed for the Annual Patient Safety Summary Report to assure annual reporting of activity of reportable events. Supporting
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>S 0406</td>
<td>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</td>
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<td>(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: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include documentation is attached.</td>
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<td>06/02/2016</td>
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4. The Licensed Clinical Social Worker for Outpatient Psychiatry (Behavioral Health) will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and the Quality Services Director will be responsible for submitting data to Medical Staff and Board of Directors. Supporting documentation is attached. The Quality Services Director will be responsible for ongoing annual submission of the Annual Patient Safety Summary, including activity of reportable events, to the Medical Staff and Board of Directors. Supporting documentation is attached.
standards for 1 directly-provided service, as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2015.

Findings include:

1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include standards for the directly-provided service of outpatient psychiatry.

2. In interview, employee #A1, Quality Services Director, on 04-12-2016 at 12:15 pm, confirmed the above and no further documentation was provided prior to exit.

include monitoring and reporting for Outpatient Psychiatry (Behavioral Health). This monitor will be reported through the established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached. 2. A cross reference of the QAPI Monitor List provided by the Indiana State Department of Health Surveyors at the time of survey to the Organization PI Plan was conducted to assure all applicable services, including Outpatient Psychiatry (Behavioral Health), is part of the hospital's QAPI program. Supporting documentation is attached. 3. Margaret Mary Health's Department Managers were reminded that any new services, including contracted services, are part of the hospital's QAPI program. Supporting documentation is attached. 4. The Licensed Clinical Social Worker for Outpatient Psychiatry (Behavioral Health) will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and the Quality Services Director will be responsible for submitting data to Medical Staff and Board of Directors. Supporting documentation is attached.
1. **Review of policy/procedure titled "Patient Care-Medication Blood Transfusion"** supplied to the surveyor by SP#4 upon request for nursing's transfusion administration policy/procedure revealed:
   a. page 5: "5. Appropriate intervals for vital signs include pre-transfusion time and date as noted on the component." signs (within 30 minutes from start of blood), 15 minutes from start of blood, 1 hour after initiating blood and on completion."
   b. page 5: "7. All blood/blood components must be transfused within 4 hours of issuance from the Blood Bank and before the blood product expiration"
time and date as noted on the component.”

2. Review of transfusion records revealed:
   a. Transfusion on P#1 (P=Patient) had no documented 1 hour vitals.
   b. Transfusion on P#6 left refrigeration at 1344 hrs but was not completed until 1800 which is greater than 4 hours.

Care RNs will include a thorough review of the Blood Transfusion policy. Supporting documentation is attached.

4. The Medical-Surgical and Special Care Manager will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and submitted to the hospital's Quality Improvement Director. Supporting documentation is attached.

410 IAC 15-1.5-8
PHYSICAL PLANT
410 IAC 15-1.5-8 (b)(2)

(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:

(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.

Based on observation and document review, the facility created conditions which resulted in a hazard to patients, public or employees in 1 instance.

Findings include:

1. On 04-11-2016 at 2:35 pm in the presence of employees #A5 and #A6, it was observed in the storage shed outside S 1118

Bldg. 00

1. All of the compressed gas cylinders in the outside storage shed by the physical plant were secured properly.
2. A review of all the compressed gas cylinders at Margaret Mary Health campuses were checked to see if properly stored and secured.
3. A memo was sent to the AirGas (vendor that provides compressed gas cylinders to Margaret Mary Health) and

06/03/2016
the physical plant area there were 2 small medical air compressed gas cylinders standing upright on the floor unsecured by chain or holder.

2. Review of a facility policy entitled Compressed Gas Cylinders, approved 03-21-2014, indicated "... cylinders should be properly secured by chain in storage areas ... so as to offer some protection against falling or being pushed over."

3. If any of the above cylinders were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.

Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM)
Findings include:

1. On 04-11-2016 at 11:00 am, employee #A5, Safety & Security Coordinator, was requested to provide documentation of PM on a dietary dishwasher and renal dialysis machine.

2. Review of a document entitled MAINTENANCE located on page 25 of the Hobart Dish Machine handbook, indicated the manufacturer indicated steps to follow for periodic maintenance.

3. Interview of employee #A5 on 04-12-13 at 2:55 pm, indicated there was no documentation of PM on the above-stated equipment and none was provided prior to exit.

4. The Director of Facilities will be responsible for the ongoing semi-annual tracking of the Preventative Maintenance Schedules for Dietary Dishwasher and Renal Dialysis Machines.

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>S 1166</td>
<td>for 2 pieces of equipment.</td>
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<td>documentation is attached.</td>
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<td>Findings include:</td>
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<td>2. A review of the Equipment</td>
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<td>Inventory List conducted by</td>
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<td>the Director of Facilities</td>
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<td>same deficiency practice</td>
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<td>3. The Dietary Dishwasher</td>
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<td>and Renal Dialysis Machines</td>
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<td>were added to the Preventive</td>
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<td>Director of Facilities.</td>
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<td>Supporting documentation is</td>
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<td>attached.</td>
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<td>4. The Director of Facilities</td>
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<td>will be responsible for the</td>
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<td>ongoing semi-annual tracking</td>
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<td>of the Preventive Maintenance</td>
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<td>Schedules for Dietary</td>
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<td>Dishwasher and Renal</td>
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<td>Dialysis Machines.</td>
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(d) The equipment requirements are as follows:
(2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:

(C) Appropriate records shall be
Based on document review and interview, the facility failed to document current electrical leakage check for 10 of 23 pieces of equipment.

Findings include:

1. On 04-11-2016 at 11:00 am, employee #A5, Safety & Security Coordinator, was requested to provide documentation of current electrical leakage checks for 23 pieces of equipment.

2. Review of facility documents indicated there was no documentation for an audiometer, computer tomography scanner, dietary dishwasher, emergency code call system, floor scrubber, gamma camera, linear accelerator, mammogram scanner, renal dialysis machine, and ultrasound machine.

3. Interview of employee #A5, on 04-12-2016 at 2:55 pm, confirmed there was no above-requested documentation. No other documentation was provided prior to exit.

kept pertaining to equipment maintenance, repairs, and current leakage checks.

1. Electrical leakage current values are not applicable to the following devices because they are either battery operated, hardwired, or dc transformer: audiometer, computer tomography scanner, dietary dishwasher, emergency code call system, floor scrubber, gamma camera, linear accelerator, and mammogram scanner. A electrical leakage check was performed on renal dialysis machines, and the ultrasound machines. Supporting documentation attached.

2. TriMedx (Biomedical Engineering Contractor) will ensure electrical leakage current values are documented in preventative maintenance notes for all applicable equipment. When electrical leakage current is not applicable to the device, i.e., the device is battery operation, hard wired, or a dc transformer, TriMedx will document the leakage current is not applicable. Supporting documentation is attached.

3. TriMedx (Biomedical Engineering Contractor) will ensure electrical leakage current values are documented in preventative maintenance notes for all applicable equipment. 4. The Director of Facilities will be responsible to ensure the documentation by TriMedx of the
ongoing triennial electrical leakage current values are documented in the preventative maintenance notes for all applicable equipment.

Based on document review and interview, the facility failed to include in its fire control plan, a provision to cooperate with firefighting authorities in 1 instance.

Findings include:

The Fire Safety Management Plan and the Code Red: Fire Response Plan were revised to include a provision to "Cooperate" with firefighting authorities. Supporting documentation is attached. A partial IDR is being requested for S-1186 due to the following facilities being inadvertently listed on the
### State of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING 04/13/2016

**Name of Provider or Supplier:** MARGARET MARY HEALTH

**Address:**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
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<td>1. Review of a facility policy entitled <strong>Fire Safety Management Plan</strong>, approved 7/14, indicated it did not include a provision to cooperate with firefighting authorities.</td>
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<td>document titled &quot;List of Eligible Sites for Survey&quot;: OS#2 - Outpatient Rehabilitation Center OS#3 - Occupational Health &amp; Wellness Clinic OS#4 - Margaret Mary Physician Partners The above sites are designated as &quot;Business Occupancy&quot; and the appropriate number of fire drills per NFPA Life Safety Code and hospital policy were conducted as appropriate for &quot;Business Occupancy&quot;. The fire drills that were conducted were documented and provided at the time of survey.</td>
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<td>2. Interview of employee #A6, Safety &amp; Security Coordinator, on 04-12-2016 at 1:10 pm, confirmed the above and no other documentation was provided prior to exit.</td>
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**State Form Event ID:** TCOS11

**Facility ID:** 004718

**If continuation sheet:** Page 11 of 11