

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2011
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NAME OF PROVIDER OR SUPPLIER FAYETTE REGIONAL HEALTH SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1941 VIRGINIA AVE CONNERSVILLE, IN47331
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005059</p> <p>Survey Date: 10-31/11-2-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: 11/29/11</p>	S0000		
S0178	<p>410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p>			

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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S0406	<p>Based on observation and interview, the hospital failed to conspicuously post the hospital license in an area open to patients and the public.</p> <p>Findings:</p> <p>1. On 11-1-11 at 10:40 am, in the presence of employee #A7, it was observed at the Healthworks offsite facility that the hospital's license was not posted in an area open to patients and the public.</p> <p>2. On that date and at that time, upon interview, staff indicated the license was not posted conspicuously.</p> <p>410 IAC 15-1.4-2(a)(1)</p> <p>(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:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the hospital failed to include 3 services</p>	S0178	<p>Responsible person: Tammy Halpin, Team Leader-Plant Operations & Security On 11/15/11 and 11/29/11 inspections of all out buildings were completed and licenses posted per requirements. Example is attached demonstrating posted license in one of the buildings. (Attachment A). Work Order for all sites (Attachment B) and specifically Healthworks (Attachment C). Method of monitoring: Monthly building inspections will be completed for licenses by a member of Plant Operations. Office Managers of each building are also responsible to report if a license is removed from their facility. Quarterly reports will be made to the Quality Action Council for the presence of appropriate licenses. (Attachment D)</p>	11/29/2011	
		S0406	<p>Responsible party for assessment and presentation at Quality Action Council is Phyllis</p>	11/16/2011	

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	<p>provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program indicated it did not include the contracted services of bioengineering, medical records consultant and tissue transplant. 2. On 11-2-11 at 2:00 pm, employee #A8 was requested to provide the above documentation and none was provided prior to exit. 		<p>Bates, AVP, Quality, Risk and Care Management. On 11/16/11 all three of the plans were completed. Contracted service for tissue transplant. Responsible person is Mary Beth Morehead, Director of Surgical Services. Tissue Qualification Form was received from Community Tissue Services and will be requested annually to assure continued compliance. (Attachment E). Additionally, the Director of Surgical Services will have quarterly reports submitted to Quality Action Council, verifying supplier's qualification form. Example of data currently being reviewed electronically in the Surgical Department is attached. (Attachment F). Thirty day incremental monitoring will continue as outlined in the QI grid attached. Contracted services for Medical Records. Responsible person is Alecia Black, Team Advisor for HIM. Consultant being aggressively recruited with the understanding that quarterly reports will be submitted to the Quality Action Council for review and acceptance by the appropriate consultant. A verbal acceptance has been procured from a RHIT and contract forwarded. Based on the attached job description, monitoring and quality improvement activities will begin in January 2012. Please see Job Description and Chart Review Schedule. (See Attachment G). Thirty day quality</p>		

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			<p>follow up will continue as outlined in attached HIM Consultant Chart Review Schedule. Correction Date contingent on hiring of Consultant. Contracted services for biomedical. Responsible person is Roy Cupp, Team Leader of IS and Biomedical. Clinical Engineering (Biomedical) will track 10% or 20 pieces of clinical equipment whose PM's are performed by outside contractors to verify performance standards. This list with results will be reported to Quality Action Council in 30 day increments starting January 2012. FRHS has historically completed checks on random vendors; this has been increased to all. Attached work orders demonstrate historical data. It was decided that our timing needs to be adjusted as verified by the work orders to reflect contracted vendor PM's. This will be adjusted to add additional vendors. Attachments:H: Trimedix PM Work Order # 0003954331 - VentilatorI: FRHS PM Work Order # 31890 - VentilatorJ: Trimedix PM Work Order # 0003866610 - Anesthesia UnitK: FRHS PM Work Order # 32169 - Anesthesia UnitMonitoring will be included in quarterly report to Quality Action Council. (Attachment L)</p>		

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S0708	<p>410 IAC 15-1.5-4 (b)(1)(2)</p> <p>(b) The organization of the medical record service shall be appropriate to the scope and complexity of the services provided, as follows:</p> <p>(1) The service shall be directed by a registered health information administrator (RHIA) or a registered health information technician (RHIT). If a full time or part time RHIA or RHIT is not employed, then a consultant RHIA or RHIT shall be provided to assist the person in charge. Documentation of the findings and recommendations of the consultant shall be maintained.</p> <p>(2) The medical record service shall be provided with the necessary direction, staffing, and facilities to perform all required functions in order to ensure prompt completion, filing, and retrieval of records. Based on document review and interview, the hospital failed to document the findings and recommendations of a medical records consultant for 8 months.</p> <p>Findings:</p> <p>1. Review of a document entitled INDEPENDENT CONSULTANT CONTRACT, dated January 1, 2010, signed by both a representative of the hospital and a Registered Health Information Technician (RHIT), indicated</p>	S0708	Skip Smith, CFO and Alecia Black, Team Advisor for HIM are in the process of recruiting an RHIA or RHIT to provide consultant services monthly for the HIM department and provide a written assessment identifying opportunities for improvement and recommend methodologies to assure compliance with Federal and State law and meet HIM standards of practice. A verbal acceptance has been procured by Skip Smith from a RHIT and contract forwarded. Based on the attached job	11/21/2011	

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	<p>the RHIT would provide consulting services, monthly for the [hospital's] Health Information Management Department and would provide a written assessment identifying any shortcomings or opportunities for improvement and suggested methodologies for bringing existing practice into compliance with federal and state law or existing standards of practice.</p> <p>2. Review of the consultant's reports indicated the most recent report was dated January 26, 2011.</p> <p>3. On 11-2-11 at 2:45 pm, employee #A8 was requested to provide documentation of the consultant's reports for the months of February through September, 2011 and upon interview, the employee indicated there were no other reports and no other documentation was provided prior to exit.</p>		<p>description and Consultant Chart Review Schedule, thirty day incremental monitoring and quality improvement activities will begin in January 2012. Please see Job Description and Chart Review Schedule. (See Attachment G). Correction Date contingent on hiring of Consultant..</p>		

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S0952	<p>410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on record review, policy/procedure review and staff interview, the facility failed to follow approved medical staff policies/procedures for two of eight transfusions reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of a procedure titled: "NU-SEC. II-E-1.8 TRANSFUSING BLOOD PRODUCTS PROCEDURE" Originated: 12/1989, Last Reviewed 3/2010, pp 3 item 13. "Vital signs are taken by licensed staff 15-minutes after the infusion is started and every hour until infused and documented on the transfusion record." Patient record review revealed: <ol style="list-style-type: none"> Transfusion #1 was stopped at 2120, 30 minute post vitals were taken at 2140, 10 minutes short of the 30 minutes required by the above policy. Transfusion #3 was stopped at 0215 and the last recorded vitals were taken at 0120 with no explanation of this 	S0952	<p>Responsible party is Beth Wampler, VP-Patient Care Services. Specifically for clinical units, Amanda Reiboldt, Team Leader for ICU/Medical Surgical units. All nursing personnel are to complete a CBL on appropriate documentation for blood transfusions. Thirty day incremental checks will include documentation that all RNs have completed CBL by 01/15/2012. (Attachment M). Report on all participants will be printed and given to Team Leader for counseling for those who did not complete. Also see attached document , Transfusion Record will be placed in the areas. (Attachment N). Timeliness of vital signs on blood infusions to be monitored quarterly by ICU and Medical Surgical Care Center. Results will be reported out on QI form at Quality Action Council for 2012. Thirty day increments to be based on attached quality sheet. Monitoring and evaluation will include quarterly reports submitted by the Team Leader of</p>	11/09/2011

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S1164	<p>contradiction.</p> <p>3. In interview on 11/1/11 between @:00 p.m. and 3:00 p.m. staff person #7 agreed the above recorded times did not follow the approved medical staff policy.</p> <p>410 IAC 15-1.5-8(d)(2)(B)</p> <p>(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:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the hospital failed to provide evidence of preventive maintenance (PM) for 7 pieces of equipment.</p> <p>Findings:</p> <p>1. On 10-31-11 at 2:35 pm, employee #A7 was requested to provide documentation of PM on a washer and dryer (asset tag 06828) in a Laundry Room. No documentation was provided prior to exit.</p>	S1164	<p>the ICU/Medical Surgical units to the Quality Action Council outlining compliance. Attachments O & P) Also see email communication outlining this quality monitoring process from Team Leader of Medical Surgical Care Center. (Attachment Q). Also see email communication from VP-Patient Care Services. (Attachment R)</p> <p>Responsible person is Tammy Halpin, Director of Plant Operations. Tammy Halpin, was not present at the time of the survey and employee #A7 was not aware of the electronic Preventative Maintenance Report. There is documentation of Preventative Maintenance on six (6) of the seven (7) pieces of equipment listed. Attached please find copies of the reports of completed Maintenance on all seven (7) pieces of equipment. Except for washer/dryer and electric range, all other preventative maintenance was completed prior to survey as</p>	11/21/2011	

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	2. On 10-31-11 at 2:40 pm, employee #A7 was requested to provide documentation of PM on a Tectrix exercycle (asset tag 09471), a refrigerator (asset tag 06827), a microwave (asset tag 06823), a stove (asset tag 06822), and a dishwasher (asset tag 06824), all used for patient treatment, located in the Inpatient Rehabilitation area. No documentation was provided prior to exit.		listed below. Please note that the washer/dryer is covered by one asset tag #06828. All Maintenance sheets are attached for your review. Attachments:S. Asset # 06828 - Washer - PM completed 11/17/2011T Asset # 09471 - Tectrix Bike, PM completed 07/01/2011U. Asset # 06821 - Refrigerator - PM completed 09/28/11 (listed on survey as #06827)V. Asset # 06823 - Micorwave Oven - PM completed 07/06/2011W. Asset #06824 - Dishwasher - PM completed 07/06/2011 X. Asset # 06822 - Electric Range - CM completed 12/02/2011Thirty day ongoing monitoring is based on documentation of all items being placed on semi-annual PM. These reports will be aggregated monthly. Please note that Asset #06822 was not in system, but a work order was completed , PM completed 12/02/2011 and this item has been placed on semi-annual PM. All items are now on routine semi-annual PM. An additional improvement as a result of this survey, a Computer Based Learning (CBL) was developed for all Team Leaders on the purchasing of new equipment and the process required before this new equipment may be placed in an area. The CBL is available and must be completed by all team members by 12-30-11 (Attachment Y).		