

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 09/18/2014
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NAME OF PROVIDER OR SUPPLIER FAYETTE REGIONAL HEALTH SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1941 VIRGINIA AVE CONNERSVILLE, IN 47331
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005059</p> <p>Survey Date: 9-15/18-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 09/29/14</p>	S000000	S-000 No Response needed for this deficiency. Mary Ann Green, RN, MSN, CPC AVP of Quality/Risk/Compliance/Privacy/Accreditation/Care Management 10/27/14 Signature Page 1 signed by Beth Wampler, VP of Patient Care Services on 10/29/14. See Attachment of Page 1 of POC	
S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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</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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	<p>written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to ensure an effective comprehensive quality assessment and improvement program in 2 instances.</p> <p>Findings:</p> <p>1. Review of a document entitled REAPPOINTMENT PROFILE DEPARTMENT OF SURGERY, for the time period 11-1-11 through 7-31-13, indicated for MD#3, an endoscopist, and MD#4, a plastic surgeon, there were the following criteria used to review physician outcomes:</p> <ul style="list-style-type: none"> Blood usage: Clinical indicators met % Mortality (excludes: ER, DNR, CMO, Hospice) % Occurrence reports related to technical/clinical skills % Infection Control Rate #Peer reviews with scored 2 or higher ("B"only) Complaints/occurrences related to communication/behavior # Occurrence reports related to lack of availability/response 	S000406	<p>S 0406 The Medical Staff Coordinator and the Credentials Medical Staff Committee has revised and approved the "Reappointment Profile-Department of Surgery and Department of Medicine" forms to reflect an effective comprehensive quality assessment and improvement program for all privileged medical staff. The "Reappointment Profile-Department of Surgery and Department of Medicine" forms were reviewed and revised to include set criteria and thresholds or all set criteria. The thresholds of all listed criteria will be reviewed by the Surgery Section Chair and the Medicine Section Chair prior to re-appointment period for each provider. Any listed criteria which are below the set threshold will be address by either the Surgery Section Chair or Medicine Section Chair and documented on the individual providers re-appointment profile Department of Surgery or Department of Medicine form. During the Credentials Committee meeting each provider re-appointment profile will be</p>	10/15/2014

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S000418	<p>2. Further review of the documents indicated there were outcomes for each of the criteria, but no Threshold Criteria. Thus, the program could not be effective because it could not be determined if the outcomes exceeded, met or did not meet the Threshold Criteria.</p> <p>3. In interview on 9-17-14 at 11:00 am, employee #A3, Medical Staff Coordinator, confirmed the above and no further documentation was provided by exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p>		<p>reviewed and discussed as action taken for any criteria measures which fall below threshold. This will be monitored through the Credentials Committee periodically as determined by the committee to ensure improvement is being made regarding the individual criteria measures which will improve patient outcomes. Revision and approval was completed by 10/15/14 from the FRHS Credential Committee. The Medical Staff Office Coordinator along with the Credential Committee Medical Staff Chair will monitor for compliance of this deficiency.</p> <p>See Attachments of: "Reappointment Profile-Department of Surgery" forms "Reappointment Profile-Department of Medicine" forms "10/15/14 Credentials Committee Minutes</p>	

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	<p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on document review and interview, the hospital failed to take appropriate action to address an opportunity for improvement found through the quality assessment performance/improvement (QAPI) program in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Meaningful Use Summary Report by Provider, for MD#3, an endoscopist, indicated MD#3 did not meet the Minimum Required % for the criteria of Diagnoses recorded, Education provided, and Medication reconciliation for transition of care. In interview on 9-17-14 at 11:00 am, employee #A3, Medical Staff Coordinator, confirmed the above. In interview on 9-17-14 at 11:00 am, employee #A3 was requested to provide documentation of action taken to address MD#3 not meeting the Minimum Required % for the above-stated criteria. No documentation was provided prior to exit. 	S000418	<p>S 0418</p> <p>The Medical Staff Coordinator and the Credentials Medical Staff Committee has revised and approved the "Reappointment Profile-Department of Surgery and Department of Medicine" forms to reflect an effective comprehensive quality assessment and improvement program for all privileged medical staff. The "Reappointment Profile-Department of Surgery and Department of Medicine" forms were reviewed and revised to include set criteria and thresholds or all set criteria. The thresholds of all listed criteria will be reviewed by the Surgery Section Chair and the Medicine Section Chair prior to re-appointment period for each provider. Any listed criteria which are below the set threshold will be address by either the Surgery Section Chair or Medicine Section Chair and documented on the individual providers re-appointment profile Department of Surgery or Department of Medicine form. During the Credentials Committee meeting each provider re-appointment profile will be reviewed and discussed as action taken for any criteria measures which fall below threshold. This</p>	10/15/2014

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S000554	<p>4. Review of a document entitled Meaningful Use Summary Report by Provider, for MD#4, an plastic surgeon, indicated MD#4 did not meet the Minimum Required % for the criteria of Diagnoses recorded, Education provided, and Medication reconciliation for transition of care.</p> <p>5. In interview on 9-17-14 at 11:00 am, employee #A3, Medical Staff Coordinator, confirmed the above.</p> <p>6. In interview on 9-17-14 at 11:00 am, employee #A3, was requested to provide documentation of action taken to address MD#4 not meeting the Minimum Required % for the above-stated criteria. No documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the hospital created 1 condition which failed to provide a healthful environment that</p>	S000554	<p>will be monitored through the Credentials Committee periodically as determined by the committee to ensure improvement is being made regarding the individual criteria measures which will improve patient outcomes. Revision and approval was completed by 10/15/14 from the FRHS Credential Committee. The Medical Staff Office Coordinator along with the Credential Committee Medical Staff Chair will monitor for compliance of this deficiency.</p> <p>See Attachments of: "Reappointment Profile-Department of Surgery" forms "Reappointment Profile-Department of Medicine" forms "10/15/14 Credentials Committee Minutes</p> <p>S 0554 The deficiency was corrected during the survey. On 9/17/14 the 2 dirty items were removed from the housekeeping</p>	10/07/2014

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S000726	<p>minimized infection exposure and risk to patients, visitors, and employees.</p> <p>Findings:</p> <p>1. On 9-15-14 at 3:25 pm, in the presence of employee #A2, Team Advisor Plant Operation, it was observed in a Housekeeping storage area off the dock, there were 6 large toilet paper dispenser rolls, 7 large hand towel dispenser rolls, and 42 packages of paper hand towels stored on an open shelf. The rolls were completely unprotected and the ends of the hand towel packages were not covered by any wrap. This posed the potential for cross-contamination of the items used on patients, employees and visitors.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to,</p>		<p>storage area. The Team Leader of EVS performed just in time training for the EVS Staff. On 9/17/14 the Custodian AM Checklist was revised to include a daily check of the housekeeping storage area to ensure compliance. On 9/18/14 a sign was posted "Please do not store working equipment in the closet which is currently being used to house clean supplies" On 10/7/14 the EVS staff was re-educated during the monthly EVS departmental meeting of the proper items to be stored in the housekeeping storage area. The Team Leader of EVS will be responsible for compliance of the housekeeping storage area. See Attachments of: "Custodian AM Checklist Revised 9-17-14" "Housekeeping Storage Area Posted Sign" "EVS Departmental Meeting Minutes 10-7-14"</p>				

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	<p>the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on observation and interview, the hospital failed to ensure the confidentiality of patient records by creating a situation in which unauthorized individuals could gain access to patient records in 1 instance.</p> <p>Findings:</p> <p>1. On 9-15-2014 at 1:15 pm, in the presence of employee #A2, Team Advisor Plant Operation, it was observed there were exposed radiology films stored in an X-ray film storage area. The door had no lock on it.</p> <p>2. In interview, on the above date and time, radiology staff indicated the door was not secured and from time to time, no staff were in the area, thus leaving the records accessible to anyone.</p>	S000726	<p>S 0726 On 10/6/14 The Team Advisor of Plant Operations ordered the 2 turnkey sets from Central Indiana Parts. Central Indiana Parts will install the 2 turnkey sets by 11/14/14 this will ensure the radiology films are secure. On 10/14/14 a policy (Securement of Medical Imaging Records While Limited Staff is on Duty) was develop to address the new process for securing the Radiology films. On 10/23/14 Radiology staff was educated on the new process and policy for securing Radiology films. Security staff will perform every 2 hour rounds to ensure the Radiology doors are locked to ensure the Radiology films are secure. The Team Leader of Diagnostic Imaging is responsible for the compliance regarding the Radiology films being secure. See Attachments of: Purchase RequisitionPolicy on Securement of Medical Imaging Records While Limited Staff is on DutyEducational Documentation/signatures on Policy on Securement of Medical</p>	11/14/2014	

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 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 review of Transfusion Policy/Procedure, Transfusion Record Review and staff interview, the facility failed to follow approved medical staff policy/procedure for five of seven transfusions administered.</p> <p>Findings include: 1. On 9/16/14 review of a policy/procedure titled: "TRANSFUSING BLOOD PRODUCTS PROCEDURE, Originated: 12/1989, Revised: 1/2013" indicated the following: a. " 9. Licensed staff take and record a new set of vital signs just before starting the infusion of the blood component The RN will observe..... Subsequent vital signs will occur at 15 minutes after the blood reaches the patient. b. 13. Vital signs are taken by licensed</p>	S000952	<p>Imaging Records While Limited Staff is on Duty</p> <p>S 0952 The deficiency was corrected during the survey. On 8/17/14 an online training power point was assigned to all nursing staff on the "Administration Guidelines for Blood Transfusion" On 9/16/14 the Team Leader of Med/Surgical and ICU Units revised the EMR electronic form called "Blood and Blood Products Administration" to include "Start/Stop Time"; Nurses Name Whom Starting/Stopping Infusion"; Revised wording to clearly state "Blood Received By"; "Nurse Starting Infusion" and "Nurse Verifying" to reflect a more defined chain of command to the blood and blood products administration process. On 9/24 and 9/25/14 the nursing staff was re-educated during the annual nursing skills fair week. The competency skills form reflects this skill set with the revised</p>	10/15/2014

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	<p>staff 15 minutes after the infusion is started. at 30 minutes, and then every hour until infused....."</p> <p>2. Review of Transfusion Records between 11:30 a.m. and 3:30 p.m. indicated:</p> <p>a. T#1 had Previtals taken the same time the infusion started not before it started.</p> <p>b. T#3 had the Previtals taken the same time the blood was being released from the laboratory and when asked how this could be, SP#1 (SP=staff person) indicated the nursing assistant may have taken the Previtals. When asked if the nursing assistant was licensed SP#1 answered: "no".</p> <p>c. T#4 also had the Previtals taken the same time the blood was released from the blood bank.</p> <p>d. T#5 had the Previtals taken as the infusion was started.</p> <p>e. T#6 had the Previtals documented as being taken after the infusion started.</p> <p>3. In interview on 9/16/14, SP #1 acknowledged the above information is as noted.</p>		<p>changes. On 10/15/14 a Med/Surgical and ICU departmental meeting was held to re-educate the nursing staff on the revisions of the E-Form documentation on "Blood and Blood Products Administration" and the Process. The Team Leader of Med/Surgical and ICU Unit will be responsible for the compliance of the revised Blood and Blood Products documentation and process. See Attachments of: Online Power Point Nursing Education on "Administration Guidelines for Blood Transfusions" Net Learning Staff Completion rate/listing from the Online Power Point Nursing Education on "Administration Guidelines for Blood Transfusions" EMR E-Form of "Blood and Blood Products Administration" Revised 9/16/14 Nursing Skills Fair Picture of Blood Transfusion Booth Nursing Skills Fair Competency Form which has Blood Products Sill set Checklist 10/15/14 Med/Surgical and ICU Departmental Meeting Minutes</p>	