

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
A000000	<p>The visit was for a re-certification survey.</p> <p>Facility Number: 005179</p> <p>Survey Date: 4-02-14 to 4-03-14</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/14/14</p>	A000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

A000052	<p>482.12((a)(8), (a)(9) MEDICAL STAFF [The governing body must:]</p> <p>(8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant -site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.</p> <p>(9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity ' s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant</p>			
---------	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.</p> <p>Based on document review and interview, the survey hospital ' s written agreement for distant-site radiology services furnished to its inpatients failed to indicate that the distant-site entity was a contractor of services of the hospital and will provide the radiology services in accordance with all Federal conditions of participation pertaining to contracted services and assure that its medical staff providing radiology services maintained their medical staff membership and privileging requirements in accordance with all Federal conditions of participation pertaining to the governing body requirements for medical providers furnishing the service. The survey hospital failed to document privileging of the radiologists associated with the distant-site entity including evidence of a medical staff recommendation based upon information supplied by the distant-site entity or based upon a credential file review for each distant-site radiologist by the survey hospital.</p> <p>Findings:</p>	A000052	<p>The Director of Nursing and Mobilex USA account manager representative amended the contract with Mobilex USA on April 18, 2014 to include that Mobilex USA will provide contracted radiology services in accordance with all Federal Conditions of participation pertaining to contracted services and would maintain their medical staff membership and privileging requirements in accordance with all Federal conditions of participation pertaining to the governing body requirements for medical providers furnishing radiology services. The Senior Vice President of Rehabilitation/Recovery Services met with the Medical Director and medical staff on April 18, 2014 to discuss Mobilex USA contract and privileging of physicians and practitioners employed by Mobilex USA. The Clinical Staff Organization Executive Committee, in coordination with the Medical Director and President/CEO will recommend that privileges be granted to physicians and practitioners employed by Mobilex USA based on information provided by Mobilex USA. The Senior Vice</p>	04/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>1. Review of the written agreement for radiology services between the survey hospital and the distant-site entity failed to indicate that the distant-site entity was a contracted service and would provide the radiology services in accordance with all Federal conditions of participation pertaining to contracted services. The agreement failed to indicate that its medical staff providing radiology services would maintain their medical staff membership and privileging requirements in accordance with all Federal conditions of participation pertaining to the governing body requirements for medical providers furnishing the service.</p> <p>2. During an interview on 4-03-14 at 1515 hours, credentialing specialist A15 confirmed that the facility lacked evidence of hospital privileging for the distant-site radiology service practitioners.</p> <p>3. During an interview on 4-03-14 at 1545 hours, Risk Manager A4 confirmed that the service agreement with the mobile radiology service lacked the indicated provisions and no further documentation was available.</p>		President of Performance and Compliance will ensure that radiology services will be reviewed at least quarterly by the CQRI (QAPI) committee .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

A000085	<p>482.12(e)(2) CONTRACTED SERVICES</p> <p>The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 15 of 27 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The list of contracted services failed to indicate the scope and nature for 12 of 24 listed services and failed to indicate a provider for a commercial kitchen dishwasher, fire extinguisher service, and a fire sprinkler service.</li> <li>Review of facility maintenance documentation indicated the following: commercial dishwasher service by CS1, fire extinguisher service by CS2, and fire sprinkler service and certification by CS3.</li> <li>During an interview on 4-03-14 at 1215 hours, staff A4 confirmed that the list of contracted services failed to indicate the scope and nature of services for 12 providers and failed to include the 3 services indicated above. The staff A4 confirmed that the list had not been maintained.</li> </ol>	A000085	The Facilities Director, VP of Risk Management and the Executive Assistant will update the list of contracted Inpatient services. The list will include, but will not be limited to providers for the commercial kitchen dish sanitizer service, fire extinguisher service, and a fire sprinkler service. In addition to creating the list, these individuals will develop the expectations for the contracted services; and they will identify the individuals responsible for evaluating the contracted services. The Facilities Director will ensure the list is updated by May 23, 2014. The review of the contracted services will occur in the CQRI (QAPI) committee on a quarterly basis.	05/23/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

A000168	<p>482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>Based on policy and procedure review and medical record review, the facility failed to ensure that the type of restraint was ordered when a restraint order was given for two of three patient records where restraint was ordered (pts. #1 and #2).</p> <p>Findings:</p> <p>1. review of the policy and procedure "Seclusion and Restraint of Inpatient Clients", procedure number IV - 502 (R 11), with an approval date of March 25, 2011, indicated:</p> <p>a. on page 6 under "QRN/Physician/APN Assessment:" (QRN = qualified registered nurse; APN = advanced practice nurse), it reads: ". 1...Determination/method of appropriate type of restraint/seclusion (physician order)."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #1 had an order to "Physically restrain for up to four (4) hours." written</p>	A000168	The Director of Nursing on April 18, 2014 revised the policy and procedure "Seclusion and Restraint of Inpatient Clients" procedure number IV – 502 (R 11) to define a physical restraint to mean a manual restraint and a 4 point restraint to mean a mechanical restraint and include that physician orders indicate the specific type of restraint to be used. The order sheet will be modified to reflect the changes in the policy by May 23, 2014. The Director of Nursing and PI Nurse will review all seclusion and restraint physician orders to ensure that the indication of the type of physical restraint is included in each seclusion and restraint order. Results of the review will be reported in the CQRI (QAPI) committee meetings quarterly.	05/23/2014
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>on 12/9/13 at 10:45 PM (on form C390)</p> <p>b. pt. #2 had an order to "Physically restrain for up to four (4) hours." written on 3/10/14 at 10:30 AM (on form C390)</p> <p>c. both restraint orders lacked indication of the type of physical restraint to be utilized</p> <p>d. the policy listed in 1. above lacked indication, in the portion of the policy that addresses practitioner orders, that the specific type of physical restraint needed to be included with the order for restraint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
A000206	<p>482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:]</p> <p>(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</p> <p>Based on policy and procedure review, personnel file review, and staff interview, the facility failed to implement its policy related to CPR (cardio pulmonary resuscitation) certification for 3 of 8 staff members (N1, N2 and N8) and failed to ensure annual training, required per policy, for 8 of 8 staff (N1 through N8)related to the AED (automated external defibrillator).</p> <p>Findings: 1. review of the policy and procedure "Mandatory Training: Monitoring and Documentation", procedure number VII-521 (R 08), with an approval date of September 17, 2012, indicated: a. on page 2 under section 4.3, it reads: "Mandatory Training Requirements:....2 Cardiopulmonary Resuscitation CPR/AED: .1 Training is required for all adult and child adolescent rehabilitation service providers, 24 hours</p>	A000206	The Director of Nursing will ensure that N1, N2, and N8 have completed CPR by May 9, 2014. The Director of Nursing on April 18, 2014 revised the policy and procedure "Mandatory Training: Monitoring and Documentation" procedure number VII – 521 (R 08) to change the training requirement regarding CPR/AED from annual to every two years at work sites where AED machines are available. The Vice President of Human Resources will ensure the creation of a spread sheet that will track the training and expiration dates for CPR/AED, CPI for all Inpatient staff. The spreadsheet will be created by May 23, 2014. Inpatient related CPR/AED and CPI training will be tracked as part of the Clinical Staff Organization Executive Committee's review of expiring licensure and certification. The Director of Nursing will be informed of any Inpatient staff that are within 60 days of their	05/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>staff, and residential staff. .2 Doctors and licensed nurses who are already certified must maintain their CPR/AED certification. .3 Staff shall receive annual training regarding CPR/AED use at worksites where AED machines are available,"</p> <p>2. review of personnel files indicated: a. staff members N1 and N2 had CPR certification which expired 1/6/14 c. staff member N8 had CPR certification that expired 3/16/14 d. staff members N1 through N8 lacked any documentation of having had annual CPR/AED education</p> <p>3. at 3:15 PM on 4/3/14, interview with staff members #50, the director of nursing and inpatient director, and #59, the RN, PI (registered nurse/performance improvement) staff member, indicated: a. the inpatient unit does have and AED b. it was unknown that the policy required annual CPR/AED education for staff c. annual education has not been occurring as indicated in the policy listed in 1. above</p>		<p>CPR/AED, CPI expiration. The Director of Nursing will notify and schedule IPU staff members into needed training prior to expiration of the required training. The Director of Nursing will not allow staff members who have expired CPR/AED, CPI training after April25, 2014 to be scheduled for work until the needed training is completed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
A000308	<p>482.21 QAPI GOVERNING BODY, STANDARD TAG</p> <p>... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>Based on document review and interview, the psychiatric facility failed to maintain an effective quality assessment and performance improvement (QAPI) program and assure that all hospital inpatient services were monitored and reviewed in a distinct and organized manner through the program.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan FY 2014 (approved 10-13) failed to indicate a process to organize and distinguish the provision of all hospital inpatient services from other mental health services reviewed through the program. The plan failed to indicate the 'Cross Functional Team' or equivalent with responsibility for monitoring and reviewing all inpatient services (including discharge planning, environmental services, laboratory, medical records and radiology services).</p>	A000308	The Senior VP of Performance and Compliance will re-write the organization's Performance Improvement Plan to include a section specific to the Inpatient Unit. The PI Plan is on a control cycle to be updated yearly. The IPU specific PI plan will indicate the cross functional committee responsible for monitoring and reviewing all IPU related services, including discharge planning, environmental services, laboratory, medical records, infection control and other contracted services. The cross functional committee will meet at least every other month. The Safety and Risk Management Committee (SARM) will no longer function as the QAPI for the Inpatient Unit. The PI Plan will be re-written by May 23, 2014. We will begin cross functional QAPI committee meetings once the plan is re-written and the monitoring activities identified. The cross functional committee will include the following membership: President/CEO Sr. VP, Rehab	05/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>2. The facility Safety Plan (no approval date) heading titled Safety and Risk Management (SARM) Committee duties failed to assure that all inpatient services were monitored and reviewed by the committee. The safety plan indicated that the SARM committee membership included the Medical Director and indicated the committee would hold monthly meetings.</p> <p>3. During an interview on 4-02-14 at 1000 hours, Risk Manager A4 indicated that the SARM meetings functioned as the hospital QAPI committee for inpatient services.</p> <p>4. The SARM meeting minutes dated 3-14-14, 1-14-14, 12-13-13, 11-08-13, 8-09-13, 7-12-13 and 6-14-13 failed to indicate that the Medical Director MD11 attended the meetings. The minutes failed to indicate that the hospital services including discharge planning, environmental services, laboratory, medical records and radiology were periodically evaluated and reviewed. The minutes failed to assure that the inpatient QAPI program monitoring documentation of required services and functions was ongoing and effective.</p> <p>5. During an interview on 4-03-14 at 1300 hours, staff A4 confirmed that the</p>		<p>and Recovery Sr. VP, Performance and Compliance VP, Risk Management Inpatient Physician Second Inpatient Physician Director of Nursing IPU Social Workers Facilities Director Inpatient Office Manager Infection Control Practitioner</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	PI plan failed to assure that hospital services were assessed and reviewed in an organized manner from other mental health services reviewed through the program. The staff A4 confirmed that the SARM minutes failed to assure that all inpatient hospital services were monitored and reviewed through the program and confirmed that no other documentation was available.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
A000748	<p>482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.</p> <p>Based on personnel file review and interview, the infection control committee failed to ensure the continuing education of the infection preventionist related to infection control practices; and based on observation and interview, the infection control committee failed to ensure the cleanliness of the pantry area refrigerator and a refrigerator and freezer located in the lower level of the building beside the medical records office.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>review of the education file for staff member #52, the infection preventionist, at 10:30 AM on 4/3/14 indicated the only education, related to infection control, for 2013 was one hour for hand hygiene as presented by the WHO (world health organization)-no documentation was found for 2012</li> <li>Interview with staff member #52 confirmed that:</li> </ol>	A000748	The Senior VP of Performance and Compliance will ensure that the Infection Control Practitioner receives ongoing continuing education by joining the Association for Professionals in Infection Control (APIC). The Infection Control Practitioner will identify and take online courses for her continuing education. The organization's Infection Control Practitioner will join APIC by May 23, 2014, and continuing education will begin immediately thereafter. The Infection Control Practitioner's continuing education will be documented in the infection control plan and will be tracked by the CQRI (QAPI) committee to ensure training occurs on a regular basis. If approved by Executive Leadership, the organization will also train two additional nurses in infection control when the next available training is offered (late in 2014). The Infection Control Practitioner and Director of Nursing will be responsible to update/create a policy pertaining to the cleaning of patient and staff refrigerators/freezers on the Inpatient Unit. The policy will define the schedule and responsibility for cleaning as well as the schedule for inspection.	05/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>a. there was no other continuing education received, related to infection prevention practices, for this infection preventionist in 2012 or 2013</p> <p>b. it cannot be determined what epidemiological expertise staff member #52 possesses to act as the infection control preventionist for the facility</p> <p>3. while on tour of the facility on 4/3/14 at 11:25 AM in the company of staff member #53, the inpatient nursing supervisor, it was observed in the patients' kitchen/pantry area that the industrial sized refrigerator was dirty with crumbs on the lower shelf and the shelf on the door</p> <p>4. interview with staff member #53 at 11:30 AM on 4/3/14 indicated it is the duty of the MHTs (mental health techs) to see that the kitchen refrigerator gets cleaned</p> <p>5. while on tour of the facility on 4/3/14 at 12:45 PM in the company of staff member #51, the risk manager, it was observed in the lower level freezer top that the bottom shelf was sticky from a spilled liquid and that the refrigerator was dirty with crumbs/debris under the vegetable drawers</p>		The policy will be written by May 23, 2014. Inspection results will be reported to the CQRI (QAPI) committee so corrective action can occur if it is needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

	<p>6. interview with staff member #51 at 1:00 PM on 4/3/14 indicated:</p> <p>a. it is unclear whose responsibility it is to clean the lower level refrigerator and freezer</p> <p>b. there is no facility policy that addresses cleaning of the refrigerators/freezers</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
A000749	<p>482.42(a)(1) INFECTION CONTROL PROGRAM</p> <p>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>Based on personnel file review and interview, the infection control committee failed to create an effective infection control plan in failing to assure the history of communicable diseases for 8 of 8 staff files reviewed (staff members N1 through N8).</p> <p>Findings:</p> <p>1. review personnel files indicated:</p> <p>a. staff members N1 and N2, housekeeping staff, lacked indication of history of disease, documentation of titer results, or documentation of immunization history for: Rubella, Rubeola, and Varicella</p> <p>b. staff members N3, N4, and N5 were RNs (registered nurses) who lacked indication of history of disease, documentation of titer results, or documentation of immunization history for: Rubella, Rubeola, and Varicella</p> <p>c. staff members N6, N7, and N8 were MHTs (mental health techs) who lacked indication of history of disease, documentation of titer results, or documentation of immunization history for: Rubella, Rubeola, and Varicella</p>	A000749	The Director of Nursing on April 21, 2014 developed policies related to the requirement of assessing inpatient unit employees' communicable disease history, documentation of titers results, or documentation of immunization history for Rubella, Rubeola, and Varicella. Director of Nursing will have immunization documentation of all current employees' communicable disease history, documentation of titers results, or documentation of immunization history for Rubella, Rubeola, and Varicella by May 23, 2014. It will be the responsibility of the Vice President of Human Resources to ensure that all future new hires for the inpatient unit have immunization documentation of the employees' communicable disease history, documentation of titers results, or documentation of immunization history for Rubella, Rubeola, and Varicella prior to the new hire being oriented to the inpatient unit. It will be the responsibility of the Infection Control Practitioner to create a list of employees at risk for an outbreak within the community for Rubella, Rubeola, and Varicella by May 23, 2014. It will be the	05/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>2. interview with staff member #50, the director of nursing and the inpatient director, at 2:30 PM on 4/3/14 indicated:</p> <p>a. the facility currently has no policy related to the requirement of communicable disease history for employees</p> <p>b. at this time, the facility is not checking communicable disease history of its employees</p> <p>c. it cannot be determined which staff might be at risk for an outbreak within the community of Rubella, Rubeola, or Varicella</p>		<p>responsibility of the Infection Control Practitioner to evaluate each inpatient employee's immunization record annually at the time of annual TB testing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014	
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
A000756	<p>482.42(b) INFECTION CONTROL LEADERSHIP RESPONSIBILITIES Standard: Responsibilities of Chief Executive Officer, Medical Staff, and Director of Nursing Services</p> <p>The chief executive officer, the medical staff, and the director of nursing must--</p> <p>(1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers; and</p> <p>(2) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>Based on document review and interview, the infection control committee failed to ensure medical staff involvement in the infection control committee, which is part of the SARM (safety and risk management) committee at this facility.</p> <p>Findings:</p> <p>1. review of the attendance records for the meetings of March 13, 2013; April 12, 2013; May 10, 2013; June 14, 2013; July 12, 2013; August 9, 2013; November 8, 2013; December 13, 2013; and January 10, 2014 indicated that no member of the medical staff was listed as "present".</p> <p>2. interview with staff member #50, the Director of Nursing, and #52, the infection preventionist, at 10:30 AM on</p>	A000756	The Senior VP of Performance and Compliance will ensure that Infection Control prioritized goals and identified problems are included in the Inpatient related section of the PI Plan/CQRI (QAPI) Program. The cross functional CQRI (QAPI) committee will monitor improvement and training programs identified by the Infection Control Practitioner, as well as the implementation of successful corrective action plans in problem areas. The CQRI (QAPI) committee will include physicians so medical staff will be actively involved. These infection control related items will be written into the PI Plan by May 23, 2014.	05/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  154014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  OTIS R BOWEN CENTER FOR HUMAN SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>4/3/14 indicated:</p> <ul style="list-style-type: none"> <li>a. the SARM committee is the infection control committee</li> <li>b. members of the medical staff are not involved with, and do not attend, the SARM meetings</li> <li>c. it is unclear how the medical staff is involved in infection control processes and issues without documentation of presence at meetings that include infection control reports, data, and discussion</li> </ul>				