

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150001	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/03/2015
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 W JEFFERSON ST FRANKLIN, IN 46131
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S 0000  Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005001</p> <p>Survey Date: 06-01/03-2015</p> <p>QA: cjl 06/12/15</p> <p>IDR Committe Meeting held on 07-20-15, Tag 1118 changed, Tag S 1160 moved to S1118, Tag 1166 deleted &amp; Tag 1186 deleted. JL</p>	S 0000		
S 0270  Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and</p>	S 0270	Pediatric quality monitoring had	06/30/2015

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>interview, the governing board failed to review a report of quality activity for 1 directly-provided service (pediatrics) for the calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the governing board minutes for calendar year 2014 indicated they did not include review of a report for the directly-provided services of pediatrics.</li> <li>2. In interview, on 6-3-2015 at 10:10 am, hospital staff #A1, Chief Nursing Officer, confirmed the above and no further documentation was provided prior to exit.</li> </ol>		<p>been done in the EmergencyDepartment, however, the monitoring showed goals were consistently met so data reporting was discontinued. This pediatric quality data is now being reported, along with all other quality monitoring, to the governing board through the Performance Improvement (PI) Council. We have also started pediatric quality monitoring on the Med/Surg Department, including retrospective data retrieval, to ensure quality monitoring of pediatric patients throughout our offered services. The pediatric quality monitoring data will be recorded on the JMH PI report form which is continuously available to PI Council members and is specifically referenced during review meetings. Pediatric quality data is collected as evidenced by attachments "S 270 PI Report ED Peds monitor.pdf" and "S 270 PI Report MedSurgPeds monitors.pdf". Carla Taylor, Manager of Emergency Services, is responsible for collecting, recording and analyzing pediatric data monthly for the Emergency Department. Shelia Pittman, Med/Surg Department Manager, is responsible to collect, record and analyze pediatric data monthly for</p>		

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S 0726  Bldg. 00	<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, the following:</p> <p>(A) A procedure for releasing information from or copies of records</p>		<p>herdepartment. This pediatric quality monitoring data was specifically referencedthrough the June 2015 PI Council electronic meeting, and again at the July 2015PI Council in-person meeting. Attachments "S 270 June 2015 PI Council MeetingEval.pdf" and "S 270 PI Council Minutes 2015-07-08.pdf" document references thepediatric-specific data as highlighted. Pediatric quality data will now beincluded in all PI Council meetings. William Mink, Quality Manager, isresponsible for ensuring pediatric data is reported to the Performancelmprovement Council in the future.</p>		

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	<p>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 document review, observation and interview, the facility failed to ensure the security of medical records (MR) in one of 1 of 7 nursing units toured.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the policy/procedure, "Record Retention Policy", last reviewed 10/12, indicated under Policy Statement: <ul style="list-style-type: none"> <li>Records developed in the hospital's course of business shall be retained in accordance with applicable federal, state, regulatory and accrediting agency laws, statutes and standards. These records will be maintained in locations where they are secure, that protects them from damage of flood, fire, other environmental threats, and limits access to only authorized individuals.</li> </ul> </li> <li>During tour of the Outpatient Surgery Unit on 6/02/15 beginning at 0950 with staff #40 (Chief Nursing Officer), MRs were observed being stored on a cart in the hallway.</li> <li>At above date and time, staff #40</li> </ol>	S 0726	The records referenced in the citation, blank forms with a patient name label affixed, are now being stored in a locked cabinet within the Surgery Department. Beth Bylsma, Surgery Department Director, implemented this new practice on 7/6/2015. A photo of the storage cabinet is attached, labeled "S 726 Surgery Record Storage Cabinet Photo.pdf". Staff responsible for the records were notified verbally and all staff in surgery received email notification of the change in practice on 7/6/2015 as evidenced by attachment "S 726 Surgery Staff Email Notification.pdf".	07/06/2015

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S 0952 Bldg. 00	<p>indicated that these are the records for the next day's scheduled surgeries. He/she indicated that the cart with the records is moved to the store room after the unit closed each day. He/she indicated that the records are not protected from fire or water damage.</p> <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 policy/procedure review, record review, and staff interview, the facility failed to follow approved medical staff policy/procedures for the administration of two of seven transfusions reviewed.</p> <p>Findings include: 1. On 6/1/15, review of a policy/procedure titled: "BLOOD PRODUCT TRANSFUSION, CODE: NR.6011.B.06, approved 7/18/14, Effective Date: 8/1/14," pp 6, which read: "16. Take patient's vital signs including</p>	S 0952	<p>Our blood transfusion policy has been slightly modified to more accurately reflect the range of time acceptable for checking a patient's post-transfusion vital signs. Attachment "S 952 NR Policy 6011 B 06.pdf" shows changes on pages 5 and 6. Policy changes were approved by Dr. Singh, Laboratory Medical Director, and by the Policy and Procedures Committee on 07/10/2015 as evidenced by email from Shelia Pittman, Policy &amp; Procedure Committee Chair, attached as "S 952 Blood</p>	07/31/2015			

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	<p>blood pressure, temperature, pulse and respirations 4 hours post transfusion, and assess again for a potential delayed transfusion reaction."</p> <p>2. On 6/2/15, review of transfusion records T#1 through T#7 revealed: T#1 had 4 hour post vitals taken at 1600 which is less than 3 hours past the recorded stop time of 1320 and again at 1900 which is more than 5 hrs past recorded stop time of 1320, and T#5 had the 4 hour post vitals taken at 0700 which is more than 5 hrs from recorded transfusion stop time of 0137.</p> <p>3. On 6/2/15, SP#1, SP#2, and SP#3 acknowledged Transfusions T#1 and T#5 did not comply with the approved policy/procedure titled: "BLOOD PRODUCT TRANSFUSION".</p>		<p>Trx Policy Approval 2015-07-10.pdf". The changes were discussed at the Nursing Leadership meeting on 7/7/2015 as evidenced by attachment "S 952 Nursing Leadership minutes2015-07-07.pdf", page 3. As stated in the minutes, managers of those departments giving blood are responsible to notify their staff of this policy change by 7/31/2015. Email notifications will be copied to William Mink, Quality Manager, to demonstrate compliance. The responsible managers are: Beth Bylsma, Surgery Director; Shelia Pittman, Med/Surg Manager; Carla Taylor, Emergency Department Manager; Michelle Bisesi, Director of Nursing. A template of the email to be sent to staff is attached as "S 952 Blood Trx Policy Changes Notification Email.pdf". Compliance with policy will be monitored monthly by Bev Hall, Blood Bank Supervisor, until at least 12/31/2015. Quality monitor data will be recorded on our existing transfusion documentation improvement form as shown in attachment "S 952 BB QM Transfusion Audit.pdf". This transfusion quality monitoring has been ongoing since March of 2014 and will be continued with the added parameter of vitals documented 4 – 6 hours post-transfusion. This quality data has been, and will continue to be, reported to the</p>	

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S 1118 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(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:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and document review, the hospital created 2 conditions which resulted in a hazard to patients, public or employees.</p> <p>Findings:</p> <p>1. Review of the operator's manual for the hospital's Zoll defibrillators indicated to daily check that a fully charged spare battery pack accompanies the unit.</p> <p>2. On 6-1-2015 at 1:00 pm in the presence of employee #A6, Maintenance Manager, it was observed there was a Zoll defibrillator on a cart in the cardiopulmonary area. It was also observed there was no spare battery pack with the defibrillator.</p>			S 1118	<p>Performance Improvement Council.</p> <p>JMH code blue response policy, attachment "S 1118 Policy Code Blue Response TX.30.03.pdf" with relevant section highlighted, shows areas where the code carts with Zoll defibrillators may be taken within our facility. All of those areas are supplied with immediate emergency generator backup power as confirmed by JMH Facilities Manager, Chris Snyder, in attachment "S 1118Facilities Manager Generator Email 2015-07-27.pdf". Zoll's recently revised defibrillator operator's manual now requires "a fully charged spare battery <b>or ready access to AC mains power...</b>" for backup power. A low battery power situation requires the user to "immediately replace the battery pack with a fully charged pack <b>or plug the R Series unit into a power</b></p>		07/27/2015

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S 1168 Bldg. 00	<p>3. In interview, at the above date and time, a cardiopulmonary staff member indicated there was a backup in biomedical engineering.</p> <p>4. On 06-02-15 at 3:35 pm in the presence of employee #A6, it was observed in a testing room at the Johnson Memorial Immediate Care Center offsite, there was 1 small compressed gas cylinder of ethanol-nitrogen standing upright on the floor unsecured by chain or holder.</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, the hospital failed to follow the manufacturer's recommendation for daily testing of 1 of 1 defibrillator.</p>	S 1168	<p><b>source...</b> Situations requiring backup power now appropriately require access to an emergency power source which includes existing AC mains. The relevant manual page 24 is attached as "S1118 Zoll OpMan REVISION pg 24.pdf" with relevant section highlighted. We believe we are in compliance with the manufacturer's current recommendations regarding backup power. In addition to having immediate emergency generator power in all areas where a defibrillator may be taken, we also have fully charged spare batteries which are readily accessible to staff at all times as shown by attachment "S 1118 Zoll SpareBatteries RT.pdf".</p> <p>Our code cart check forms and policy have been updated to include all items previously missing; condition, electrodes, cables and connectors. The</p>	07/14/2015	

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the manufacturer's (Zoll) manual for a hospital defibrillator, indicated a recommended a checklist of tests and procedures to be performed daily on the device. The Zoll Operator's Checklist for R Series Product indicated the following checks: <ul style="list-style-type: none"> <li>1. Condition</li> <li>2. Hands-free Therapy electrodes</li> <li>3. Paddles</li> <li>4. Inspect cables for cracks, broken wire, connector</li> <li>5. Batteries</li> <li>6. Disposable supplies</li> <li>7. Operational checks</li> </ul> </li> <li>Review of hospital document DIVISION P- NURSING SERVICES, CODE: NR.6011.C.19, approved 11/21/14 entitled CODE CART CHECK POLICY, and a document entitled DAILY CODE CART CHECKLIST, UNIT CCU/PCU, Month May, YEAR 2015, indicated the following tests and procedures were not performed: <ul style="list-style-type: none"> <li>Condition</li> <li>Hands-free Therapy electrodes</li> <li>Paddles</li> <li>Inspect cables for cracks, broken wire,</li> </ul> </li> </ol>		<p>batteries have been addressed as a disputed item under tag S1160. We do not have paddles with our defibrillators so that item was not added to our check form or policy. Our revised code cart check policy, attached as "S1168 Revised Code Cart Check Policy NR 6011 C 19.pdf", was approved by our Policy &amp; Procedure Committee on 7/10/2015 as evidenced by email from Committee Chair Shelia Pittman attached as "S 1168 Revised Code Cart Check Policy Approval.pdf". The new adult and pediatric code cart check sheets are attached as "S 1168 Defib Check Sheet Adult Cart.pdf" and "S 1168 Defib Check Sheet Peds Cart.pdf". The new check forms have been approved by our Forms Committee for immediate use as evidenced by attachment "S 1168 Code Cart CheckForms Approval.pdf". Email notification, attachment "S 1168 Email Notice Mgrs Staff Defib Checks 2015-07-13.pdf", was sent to department managers and staff on 7/13/2015 to begin using the new forms immediately. Managers responsible for immediately implementing form and procedure changes are</p> <ul style="list-style-type: none"> <li>· Beth Bylsma, Surgery</li> <li>· Michelle Bisesi, Maternity and Acute Rehab</li> <li>· Nina Patterson, CCU &amp; PCU</li> <li>· Shelia Pittman, Med/Surg/Peds</li> <li>· Carla Taylor, Emergency</li> <li>· Hope Lowhorn, Cardiology</li> <li>· Brenda Wilkerson,</li> </ul>		

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	connector Batteries		Respiratory Therapy		