STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE PSYCHIATRIC CHILDREN'S CENTER	3300 E MORGAN AVE EVANSVILLE, IN 47715

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A 0000 Bldg. 00	This visit was for the recertification of a hospital. Dates of survey: 05/08/17 to 05/10/17 Facility number: 005966 QA: 05/18/17 LH	A 0000		
A 0273 Bldg. 00	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Based on document review and interview, the quality program failed to do the following: a) show measurable improvement in indicators for 3 of 4 indicators (Child and Adolescent Needs and Strengths (CANS) discharge, Discharge Medical Records (MR) and Dietary services) b) incorporate quality indicator data for 4 of 4 indicators (Medication errors, CANS discharge, Discharge MR and Dietary) c) measure performance that assesses processes of care, hospital service and operations for 2 of 4 indicators (Discharge MR and Dietary) d) analyze performance that assesses processes of care, hospital service and operations for 3 of 4 indicators (CANS discharge, Discharge MR and Dietary) e) have the governing body (GB) specify the frequency and detail of data collection for 4 of 4 indicators (Medication errors, CANS discharge, Discharge MR and Dietary) Findings include: 1. Review of quality program documentation indicated that it did not include the following: a) evidence that showed measurable improvement in indicators for	A 0273	A 0273 a) Med errors – Med errors are reported as they occur. Forms filled out by Nursing Staff are collected by the Director of Nursing. These Med errors are reported to the Pharmacy Director who then reports them at the Quarterly Pharmacy meeting. Pharmacy meeting minutes to include an attachment of the Quarterly Med Error Report will be part of the ongoing QI agenda. b) CANS – On a CANS assessment, 3 of 5 areas need to show improvement from time of admission to time of discharge, indicating an ability for the child to move to a lower level of care. A graph is compiled by the CANS computer software program semi-annually to show CANS results at discharge for all children discharged during the previous 6 months. This graph is shown in at least 2 of the 4 Quarterly Governing Body meetings by the Clinical Director and will be included in the minutes. It will now be shared with Executive Staff on a quarterly basis and will be added to the ongoing QI agenda. c) Dietary – DMHA will convene a routinely scheduled Food Service Advisory Committee to focus on contractual and quality issues. DMHA will also implement a food service audit plan which will consist of periodic on-site reviews at each facility to evaluate food operation conditions pertaining to	06/22/2017

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	CANS discharge, Discharge Medical Records (MR) and Dietary services b) incorporation of quality indicator data for Medication errors, CANS discharge, Discharge MR or Dietary c) measure of performance that assessed processes of care, hospital service and operations for Discharge MR or Dietary services d) analysis of performance to assess processes of care, hospital service and operations for CANS discharge, Discharge MR and Dietary e) the frequency and detail of data collection for Medication errors, CANS discharge, Discharge MR or Dietary specified by the hospital's GB 2. Review of documents titled Quality Improvement Minutes dated 4/4/17, 3/21/17, 2/21/17, 2/7/17, 1/10/17, 12/13/16, 11/29/16, 11/15//17 (sic), 10/18/16, 9/27/16, 9/13/16, 6/14/16, 5/24/16 and 4/12/16 lacked documentation of measurable improvement in indicators, lacked documentation of indicator analysis or tracking details being integrated into the committee meetings, lacked documentation of any indicator data having been submitted to or reviewed by the quality program/committee and lacked documentation of the program		410-IAC-7-24. Any deficiency cited during this audit process, will require the food Contractor to submit a written corrective action plan to DMHA within three (3) business days from the date of notification. The Contractor will be required to implement the corrective action plan within ten (10) calendar days. The only exception will be upon mutually agreed timelines by DMHA, SOF Superintendent, and the Contractor. d) Discharge Medical Record – The Medical Record is audited 30 days after discharge by the Health Information Services Department to ensure timeliness and completion of all medical record entries before the record is closed. The results of this audit is reported in quarterly HIS Committee meetings. HIS Committee meeting minutes, with an attachment of the Discharge Medical Record Audit report, will be included in the ongoing QI agenda. The QI Program Director is the Executive Staff representative on the HIS Committee. e) The Superintendent is the designated Governing Body representative. The Governing Body meeting minutes will be enhanced to include the documentation of the frequency and detail of Quality Improvement data by summarizing the reports made through the QI agenda template as part of	

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	committee having the GB specify frequency or detail of data collection for any indicators. 3. Review of GB (Governing Body) meeting minutes dated 1/24/17, 11/2/16, 7/27/16 and 4/26/16 lacked documentation of frequency and detail of quality program data collection. 4. On 5/10/17, in interview beginning at 10:30 am, A6, Quality Improvement, verified that QI (Quality Improvement) Committee minutes lacked documentation of data or details for the quality indicators (pharmacy/medication errors, CANS discharge, or discharged MR) and lacked documentation of quality monitoring of dietary services. A6 also indicated the GB meeting minutes lacked documentation of their specification for frequency and detail of QI data collection.		Executive Staff meetings.	
A 0286 Bldg. 00	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...			

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	(c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. Based on document review and interview, the hospital failed to ensure clear expectations for safety were established for one facility. Findings: 1. Review of hospital policies lacked documentation of a policy for staff training or communication to convey expectations for patient safety. 2. On 5/10/17, in interviews beginning at 10:30 am, A1, Superintendent, indicated that the hospital did not have documentation of staff training or communication to convey expectations for patient safety related to steps to take in a situation that feels unsafe, how to	A 0286	Per Policy, all new employees receive two weeks of General Orientation followed by department-specific orientation. The orientation schedule has been modified to more accurately define safety and incident reporting. The orientation also includes review of Environment of Care Management Plan, and Hospital Policies and Plans. In addition, the Bridge Building program on which all staff are trained, stresses recognition of unsafe situations with the children and appropriate action depending on level of behavior escalation. The policy H2 which reflects new hire orientation and annual training is being modified by the QI Program Director to more accurately reflect the topics of orientation which include safety and incident reporting.	06/22/2017

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	report adverse patient events, medical errors or near misses/close calls.			
A 0297 Bldg. 00	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort. Based on document review and interview, the hospital QAPI (Quality Assessment Performance Improvement) Program failed to document performance improvement projects conducted, reasons	A 0297	An approval signature sheet for the Governing Body has been added to the Quality Improvement Plan. The Executive Staff Committee encompasses the Quality	06/22/2017

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	for conducting projects and/or measurable progress achieved on projects within the past 4 quarters for 1 facility. Findings include: 1. Review of hospital documents, including the policy titled Quality Improvement, last reviewed 10/16; the Quality Improvement Plan 2016-17, unable to determine approval date and the document titled Quality Improvement Program Evaluation 15-16 lacked documentation of performance improvement projects. 2. Review of documents titled Quality Improvement Minutes dated 4/4/17, 3/21/17, 2/21/17, 2/7/17, 1/10/17, 12/13/16, 11/29/16, 11/15//17 (sic), 10/18/16, 9/27/16, 9/13/16, 6/14/16, 5/24/16 and 4/12/16 lacked documentation of performannce improvement projects. 3. On 5/10/17, in interview beginning at 10:30 am, A6, Quality Improvement, indicated the quality program may have conducted a study/project on restraints and verified that the QAPI Plan did not have documentation of projects, nor did meeting minutes for the past 4 quarters. No further documentation was obtained.		Improvement Committee. The QI section of the Executive Staff meeting agenda will be expanded by the QI Program Director to incorporate improvement projects, monitoring activities, findings, and any plans of correction or follow-up. The information from the QI meetings, through use of the agenda template that has been developed by the QI Director, will be used to more accurately reflect the in the QI program evaluation improvement projects and results.	

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A 0308 Bldg. 00	482.21 QAPI GOVERNING BODY, STANDARD TAG ... 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. Based on document review and interview, the hospital governing body (GB) failed to ensure that the QAPI (Quality Assurance Performance Improvement) included services furnished under contract for 2 of 4 contracted services (dietetic services and laboratory) within the past 4 quarters. Findings include: 1. Review of the policy titled Governing Body Policy for State Owned or Operated Facilities indicated that the responsibilities of the GB include: Promoting performance improvement. The policy was approved 10/21/13. 2. Review of the policy titled Quality Improvement (QI), last reviewed 10/2016 indicated the following: Quality and appropriateness of contracted services are monitored and issues addressed based on results. - Ongoing tracking of all	A 0308	A tracking form has been developed by the Medical Director and Nurse Practitioner to more thoroughly monitor the quality of all laboratory services provided. Results will be part of the ongoing QI agenda (which will be reviewed at Executive Staff meetings at least monthly). DMHA will convene a routinely scheduled Food Service Advisory Committee to focus on contractual and quality issues. DMHA will also implement a food service audit plan which will consist of periodic on-site reviews at each facility to evaluate food service operation conditions pertaining to 410-IAC-7-24. Any deficiency cited during this audit process will require the food Contractor to submit a written corrective action plan to DMHA within three (3) business days from the date of the notification. The Contractor will be required to implement the corrective action plan within ten (10) calendar days. The only exception will be upon mutually agreed timelines by DMHA,	06/22/2017

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	contracted services. - Information sharing occurs: During QI Committee... Process may result in: Change in service provider... Change in policies... No change. 3. Review of documents titled Quality Improvement Minutes dated 4/4/17, 3/21/17, 2/21/17, 2/7/17, 1/10/17, 12/13/16, 11/29/16, 11/15//17 (sic), 10/18/16, 9/27/16, 9/13/16, 6/14/16, 5/24/16 and 4/12/16 lacked documentation of assessment or monitoring of the contracted dietetic or laboratory services. 4. Review of Department Monitoring Activities reports dated FY (fiscal year) 16-17, lacked documentation of dietetic or laboratory services. 5. On 5/10/17 at approximately 1:00pm, A6, Quality Improvement, verified that QI meeting minutes lacked documentation of monitoring or assessment of dietetic and laboratory services.		SPH Superintendent, and the Contractor. Results will be requested for inclusion in the QI minutes as well as Governing Body minutes.	
A 0622 Bldg. 00	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. Based on document review and interview, the hospital failed to ensure 2	A 0622	Dietary Services is contracted by the State of Indiana for several Indiana	06/22/2017

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	of 2 dietary staff were competent in their respective duties for one facility. Findings include: 1. Review of personnel policies indicated the following: A. The policy titled Orientation and Staff Development, last revised 9/15: Staff will complete a new employee orientation within the first week of hire including (hospital) orientation and specific departmental orientation. B. The policy titled Staff Competence, last approved 9/15: In order to promote a performance-based culture and staff competency in the area of job responsibility, competence is measured and evaluated through various means. All New Hires: Attend general orientation... Attend department orientation including department-specific items... Work Profiles: Each employee has an individual work profile which delineates job responsibilities and competency expectations. 2. Review of the policy titled Quality Improvement, last reviewed 10/16, indicated the following: The recommendation for contractual service provider's privileges results from monitoring of services rendered and evaluation of demonstrated competence		State Psychiatric Hospitals. Locally, we will make sure we receive copies of orientation checklists, job descriptions, and competencies for any employees from the on site Dietary Manager of this food service company who serve food out of our kitchen. Servers at EPCC are based at ESH where all preparation, cooking, and storage of food occurs. Food is only served at EPCC. In quarterly meeting minutes, the agenda will include reports of any new employee orientation.	

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	by designated staff conducting monitoring activities. 3. Personnel file review for contracted dietetic staff P9 and P10 indicated the following: A. P9, server, was hired 7/1/16. The file lacked documentation of hospital orientation, department orientation, or competency evaluations. B. P10, director of kitchen, was hired 1/30/17. The file lacked documentation of hospital orientation, department orientation, fire safety and bloodborne pathogen training or competency evaluations. 4. On 5/10/17 at approximately 1:00pm, A6, Quality Improvement, verified that the facility lacked documentation of employee orientation to the hospital or to the dietary department of the hospital and lacked documentation of evaluation of demonstrated competency for the contracted dietetic employees.			
A 0749 Bldg. 00	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.			

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	Based on document review and interview, the infection control committee failed to follow policy/procedure to prevent, identify and manage infections and communicable diseases in health care workers for 8 (N1, N3, N6, N7, N9, N11, N12, N14) of 14 personnel files reviewed. Findings include: 1. Infection Control Plan 2017, Employee Infection Control Issues, indicated on page 16: "The CDC recommends that all healthcare workers be immune to measles and rubella. Immunizations against measles, mumps, rubella, and chicken pox can avoid causing harm to patients by preventing transmission of hese diseases. Immunization information required of all staff: measles, mumps, rubella, chicken pox". 2. Review of personnel files: A. N1 (Registered Nurse [RN]) hired on 11/23/09, N3 (RN) hired on 1/8/07, N6 (RN) hired on 12/12/16, N9 (Behavioral Health Recreational Attendant [BHRA] hired on 4/24/17, N11 (BHRA) hired on 4/3/17, N14 (BHRA) hired on 10/19/15 lacked documentation of immunity to measles, mumps, rubella	A 0749	The Employee Infection Control portion of our facility's Infection Control Plan will be revised to state that, at this time, the State of Indiana does not require healthcare workers to provide documentation of immunizations. EPCC will consider the CDC guidelines for immunization recommendations; however, these guidelines will not be a condition of employment. At time of hire, immunization records will be requested by the Director of Nursing or the Infection Control Nurse, but will not be made a condition of employment. Our Employee Infection Control - Immunizations portion of our Infection Control Plan has also been revised to include a statement explaining that, in the event of an outbreak or an individual employee diagnosis of varicella, shingles, measles, mumps, or rubella, employees who do not have immunizations or proof of immunity on file will be placed on leave until the outbreak has ceased or the employee is no longer contagious, symptom free, and cleared by their physician.	06/22/2017

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	and chicken pox. B. N7 (Infection Control Nurse) hired on 2/19/11 and N12 (BHRA) hired on 7/4/14 lacked documentation of immunity to varicella. 3. Staff N15 (Director of Nursing) was interviewed on 5/9/17 at approximately 0945 hours and confirmed the above-mentioned personnel files lacked documentation of immunity to measles, mumps, rubella and chicken pox. Staff N15 confirmed the facility should be following the recommended CDC guidelines for healthcare workers as outlined in the facility's 2017 Infection Control Plan.			