

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154009	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2014
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NAME OF PROVIDER OR SUPPLIER HAMILTON CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 620 8TH AVE TERRE HAUTE, IN 47804
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A000000	<p>This visit was for a recertification of a hospital.</p> <p>Dates of survey: 10/6/2014 through 10/8/2014</p> <p>Facility number: 005174</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger, CFM Medical Surveyor</p> <p>QA: claughlin 10/27/14</p>	A000000		
A000043	<p>482.12 GOVERNING BODY</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions</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>specified in this part that pertain to the governing body ...</p> <p>Based on document review and staff interview, it was determined that the Governing Body failed to ensure written Medical Staff bylaws and Medical Staff Rules and Regulations for effectively carrying out its responsibilities for the conduct of the hospital. The facility failed to ensure which categories of practitioners are eligible candidates for appointment to the medical staff for the hospital (see A 045); failed to appoint members to the medical staff (see A 046); failed to ensure the Medical Staff have bylaws (see A 047); failed to approve written Medical Staff bylaws that describe the privileging process to be used by the hospital (see A 050); and failed to have written criteria for appointment to the medical staff and granting of medical staff privileges that are not dependent solely upon certification, fellowship, or membership in a specialty body or society (see A 051).</p>	A000043	<p>Tag A 043 Governing Body</p> <p><u>Corrective Action(s):</u> Hamilton's response and Plan of Correction ("POC") for Tag A 043 is outlined below in Hamilton's response and POCs for each of the following: Tag A 045, Tag A 046, Tag A 047, Tag A 050, and Tag A 051. The details of the respective POCs are incorporated by reference and collectively represent the POC for Tag A 043.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Chief Executive Officer ("CEO") and Board of Directors ("Board") are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	11/19/2014

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A000045	<p>The cumulative effect of these systematic problems resulted in the hospital's inability to ensure an effective Governing Body that is legally responsible for the conduct of the hospital.</p> <p>482.12(a)(1) MEDICAL STAFF [The governing body must] determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. Based on documentation review and staff interview, the Governing Body failed to ensure which categories of practitioners are eligible candidates for appointment to the medical staff for the hospital.</p> <p>Findings included:</p>	A000045	<p>Tag A 045 Medical Staff</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an</p>	11/13/2014
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	<p>1. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Governing Board failed to ensure the Medical Staff have bylaws to define categories of practitioners that are eligible candidates for appointment to the medical staff. The Medical Staff does not have medical staff bylaws.</p> <p>2. The facility lacked documentation that the Governing Body had required the Medical Staff to have medical staff bylaws that addressed the categories of practitioners that are eligible for appointment to the medical staff.</p>		<p>organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, Hamilton's Chief Medical Officer ("CMO") held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including which categories of practitioners are eligible candidates for appointment to the Medical Staff.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include identification of which categories of practitioners are eligible candidates for appointment to the Medical Staff.</p>		

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			<p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment within each of the identified categories and consistent with the Medical Staff Bylaws and Credentialing Policy and Process. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO</p>	

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			<p>and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14 Tag A 045 Medical Staff</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, Hamilton's Chief Medical Officer ("CMO") held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including which categories of practitioners are eligible candidates for appointment to the Medical Staff.</p>	

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			<p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include identification of which categories of practitioners are eligible candidates for appointment to the Medical Staff.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. 	

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A000046	482.12(a)(2) MEDICAL STAFF - APPOINTMENTS [The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff. Based on documentation review and staff interview, the Governing Body failed to appoint members to	A000046	<ul style="list-style-type: none"> Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment within each of the identified categories and consistent with the Medical Staff Bylaws and Credentialing Policy and Process. Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 046 Medical Staff Appointments</p> <p><u>Corrective Action(s):</u></p>	11/19/2014

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	<p>the medical staff.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Governing Board (Board of Directors) meeting minutes were reviewed for the previous 12 months and lacked documentation of the recommendations of appointment from the existing medical staff. The hospital has 7 medical staff members that are employees of the hospital. 2. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff are not appointed by the Governing Board. The Medical Staff does not have medical staff bylaws. 		<p>Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19//14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval</p>		

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			<p>of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws. During this special meeting, consistent with the Medical Staff Bylaws, Hamilton's Board will also review and take action related to the applications for membership and privileges of the CMO and the Medical Director for Hospitalist Services.</p> <p>Following the Board's approval of the Medical Staff Bylaws and the granting of membership and privileges for the CMO and Medical Director for Hospitalist Services, the MSEC structure and functions will be formalized and operational, and the MSEC will assume responsibilities for reviewing and recommending actions on the remaining applicants through the Medical Staff process beginning</p>	

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A000047	482.12(a)(3) MEDICAL STAFF - BYLAWS [The governing body must] assure that the medical staff has bylaws.		11/19/14. <u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities: · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance. <u>Date of Completion:</u> 11/19/14		

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	<p>Based on staff interview, the Governing Body failed to ensure the Medical Staff has bylaws.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff does not have bylaws.</p>	A000047	<p>Tag A 047 Medical Staff Bylaws</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing</p>	11/13/2014

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			<p>physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC.</p>		

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A000050	<p>482.12(a)(6) MEDICAL STAFF - SELECTION CRITERIA [The governing body must] ensure that criteria for selection are individual character, competence, training, experience, and judgement.</p> <p>Based on document review and staff interview, the Governing Body failed to approve written Medical Staff bylaws that ensure that criteria for appointment to the Medical Staff address individual character, competence, training, experience and judgement for one (1) Medical Staff.</p> <p>Findings included:</p> <p>1. The 2014 Governing Board bylaws and 2014 Governing Board minutes indicated lack of written Medical Staff bylaws or Medical Staff Rules and Regulations that describe the criteria for selection to the medical staff to include individual character, competence, training, experience, and</p>	A000050	<p>Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 050 Medical Staff Selection Criteria</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including</p>	11/13/2014

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	<p>judgement.</p> <p>2. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) the Medical Staff are not appointed by the Governing Board and the Medical Staff does not have medical staff bylaws.</p>		<p>selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p>		

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			<p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, which shall include consideration of eligibility requirements and selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner through the Medical Staff process. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC.</p>		

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A000051	<p>482.12(a)(7) MEDICAL STAFF - PRIVILEGES ON STAFF [The governing body must] ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.</p> <p>Based on document review and staff interview, the Governing Board failed to ensure the Medical Staff have medical staff bylaws that ensure medical staff membership was not dependent solely upon certification, fellowship or membership in a specialty body or society.</p> <p>Findings included:</p> <p>1. The 2014 Governing Board bylaws and 2014 Governing Board minutes indicated lack of written Medical Staff bylaws or Medical Staff Rules and Regulations that described staff privileges which are not dependent solely upon</p>	A000051	<p>Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 051 Medical Staff Privileges of Staff</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to</p>	11/19/2014

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	<p>certification, fellowship, or membership in a specialty body or society.</p> <p>2. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff are not appointed by the Governing Board and the Medical Staff does not have medical staff bylaws.</p>		<p>offer advice and recommendations regarding the various contents, including consideration of the expectation that the granting of membership and/or privileges in the Hospital is not dependent solely on certification, fellowship or membership in a specialty body or society.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include consideration of the expectation that the granting of membership and/or privileges in the Hospital is not dependent solely on certification, fellowship or membership in a specialty body or society.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of</p>	

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A000263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of		Medical Staff Bylaws. <u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities: · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. Completion Date: 11/19/2014				

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	<p>the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>Based on document review and staff interview, it was determined that the hospital failed to ensure an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program which is effective in carrying out its responsibilities for the conduct of the hospital. The facility failed to analyze, and track quality indicators and other aspects of performance that assess processes of care, hospital service and operations (see A273); failed to identify opportunities for improvement and changes that will lead to improvement (see A283). The governing body failed to ensure that the program reflects the complexity of the hospital's organization and services; involves</p>	A000263	<p>Tag A 263 QAPI</p> <p><u>Corrective Action(s):</u> Hamilton's response and Plan of Correction ("POC") for Tag A 263 is outlined below in Hamilton's response and POCs for each of the following: Tag A 273, Tag A283, Tag A 308, and Tag A 309. The details of the respective POCs are incorporated by reference and collectively represent the POC for Tag A 263.</p> <p><u>Responsible Person(s):</u> Hamilton's Executive Director of Organizational Improvement and Corporate Compliance, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	11/19/2014

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A000273	<p>all hospital departments and services (see A308); failed to ensure an ongoing program for quality improvement and patient safety that is defined, implemented, and maintained and that the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and all improvement actions are evaluated (see A309).</p> <p>The cumulative effect of these systematic problems resulted in an inability to ensure an effective quality and improvement program that is legally responsible for the conduct of the hospital.</p> <p>482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be</p>				

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	<p>limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ...</p> <p>(2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations.</p> <p>(b)Program Data</p> <p>(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.</p> <p>(2) The hospital must use the data collected to--</p> <p>(i) Monitor the effectiveness and safety of services and quality of care; and</p> <p>(3) The frequency and detail of data collection must be specified by the hospital's governing body.</p> <p>Based on document review, the facility failed to ensure 7 of 7 services provided by contractors and 7 of 7 non-contracted services as part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Quality Assessment and Performance Improvement Plan (last reviewed 1/2013) indicated all</p>	A000273	<p>Tag A273 Data Collection & Analysis</p> <p><u>Corrective Action(s):</u> Hamilton's Board has delegated to its Professional Affairs Committee ("PAC"), on its behalf, functions related to the review of the Quality and Performance Improvement program, including the review and approval of the program for measuring, tracking, and analyzing quality indicators and performance outcomes designed to assess processes of care, Hospital services, and operations. The PAC's responsibility for oversight includes expectations for the</p>	11/19/2014			

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	<p>services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. Review of the facility's Performance Improvement Plan indicated it did not include contracted services: Pharmacy, Biohazard Waste, Laundry, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, and Dietetic Services and did not include monitoring the following internal services: Medical Records. Laundry (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency.</p> <p>3. At 10:15 AM on 10/7/2014, staff member #4 (Executive Director of Quality Improvement) confirmed contracted services: Pharmacy, Biohazard Waste, Laundry, Maintenance, Radiology-Diagnostic,</p>		<p>program to incorporate quality indicators and performance data from all internal and contracted services, and for the use of data collected to monitor the effectiveness and safety of services and quality of care. The Board has outlined an expectation that the PAC shall periodically review reports from the Quality and Performance Improvement program, and shall review the plan and activities of the Quality and Performance Improvement program on an annual basis.</p> <p>On or before 11/12/14, Hamilton's Organizational Improvement and Corporate Compliance staff will communicate with key contacts from all internal and contracted Hospital services to clarify expectations regarding the designation and establishment of quality and performance indicators for each service area, expectations for the reporting of monitoring data on a quarterly basis, or more frequently as indicated, and as needed, expectations for collaboration in the evaluation of performance data and implementation of performance improvement initiatives.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the renewed activities</p>	

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	Psychology-Telepsychology, and Dietetic Service Services and non-contracted services: Medical Records, Laundry (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency were not part of the hospital's comprehensive quality assessment and improvement (QA&I) program.		and expectations as outlined to ensure a comprehensive and focused assessment of the Hospital's Quality and Performance Improvement Program. On 11/19/14, Hamilton's Organizational Improvement and Corporate Compliance staff shall outline a reporting schedule and process flow to ensure that relevant information is being reported and, as indicated, acted upon through appropriate leadership and committee oversight structures. This reporting schedule and process flow will be implemented with reporting responsibilities beginning with December 2014 reporting schedule. - <u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Quality and Performance Improvement initiatives through the following activities: · Hamilton's Organizational Improvement and Corporate Compliance department will monitor data reporting each month to ensure reports are received from all internal and contracted Hospital services, consistent with the established reporting schedule and expectations. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations.		

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A000283	<p>482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement.</p> <p>(c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements</p>		<p>All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director of Organizational Improvement and Corporate Compliance, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	

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	<p>are sustained.</p> <p>Based on documentation review and staff interview, the hospital failed to identify opportunities for improvement and changes that will lead to improvement for 14 of 14 services.</p> <p>Findings included:</p> <p>1. Review of the facility's Performance Improvement Plan and 2013/2014 Quality minutes for the hospital indicated it did not include contracted services for improvement and changes: Pharmacy, Biohazard Waste, Laundry, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, and Dietetic Services and did not include internal services for improvement and changes: Medical Records. Laundry (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency.</p>	A000283	<p>Tag A283 Quality Improvement Activities</p> <p><u>Corrective Action(s):</u> Hamilton's Board has delegated to its Professional Affairs Committee ("PAC"), on its behalf, functions related to the review of the Quality and Performance Improvement program, including the review and approval of the program for measuring, tracking, and analyzing quality indicators and performance outcomes designed to assess processes of care, Hospital services, and operations. The PAC's responsibility for oversight includes expectations for the program to incorporate quality indicators and performance data from all internal and contracted services, and for the use of data collected to monitor the effectiveness and safety of services and quality of care. The Board has outlined an expectation that the PAC shall periodically review reports from the Quality and Performance Improvement program, and shall review the plan and activities of the Quality and Performance Improvement program on an annual basis.</p> <p>On or before 11/12/14, Hamilton's Organizational Improvement and Corporate Compliance staff will communicate with key contacts from all internal and contracted</p>	11/19/2014

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	2. At 10:30 AM on 10/8/2014, staff member #2 (Chief Medical Officer) confirmed that the hospital was not specific on monitoring all services that affect the hospital.		<p>Hospital services to clarify expectations regarding the designation and establishment of quality and performance indicators for each service area, expectations for the reporting of monitoring data on a quarterly basis, or more frequently as indicated, and as needed, expectations for collaboration in the evaluation of performance data and implementation of performance improvement initiatives.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the renewed activities and expectations as outlined to ensure a comprehensive and focused assessment of the Hospital's Quality and Performance Improvement Program.</p> <p>On 11/19/14, Hamilton's Organizational Improvement and Corporate Compliance staff shall outline a reporting schedule and process flow to ensure that relevant information is being reported and, as indicated, acted upon through appropriate leadership and committee oversight structures. This reporting schedule and process flow will be implemented with reporting responsibilities beginning with December 2014 reporting schedule.</p>		

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A000308	482.21 QAPI GOVERNING BODY, STANDARD TAG		<p>- <u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Quality and Performance Improvement initiatives through the following activities:</p> <ul style="list-style-type: none"> Hamilton's Organizational Improvement and Corporate Compliance department will monitor data reporting each month to ensure reports are received from all internal and contracted Hospital services, consistent with the established reporting schedule and expectations. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations. All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director of Organizational Improvement and Corporate Compliance, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	

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	<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 staff interview, the facility failed to involve all hospital departments and services in the Quality and Improvement program: Pharmacy, Biohazard Waste, contracted Laundry, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, Dietetic Services, Medical Records, Laundry (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency.</p> <p>Findings included:</p> <p>1. The Bylaws of Hamilton Center, Inc did not address how the Governing Body will oversee the quality improvement program for the hospital.</p>	A000308	<p>Tag A308 QAPI Governing Body</p> <p><u>Corrective Action(s):</u> Hamilton's Board has delegated to its Professional Affairs Committee ("PAC"), on its behalf, functions related to the review of the Quality and Performance Improvement program, including the review and approval of the program for measuring, tracking, and analyzing quality indicators and performance outcomes designed to assess processes of care, Hospital services, and operations. The PAC's responsibility for oversight includes expectations for the program to incorporate quality indicators and performance data from all internal and contracted services, and for the use of data collected to monitor the effectiveness and safety of services and quality of care. The Board has outlined an expectation that the PAC shall periodically review reports from the Quality and Performance Improvement program, and shall review the plan and activities of the Quality and Performance Improvement program on an</p>	11/19/2014

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	<p>2. The 2014 Hamilton Center, Inc Organizational Plan indicated it addresses the entire organization and not specifically the hospital. The inpatient services of the plan do not have a hospital-wide quality assessment and performance improvement efforts that addresses priorities for improved quality of care and patient safety and that all improvement actions are evaluated. The ongoing program for quality improvement and patient safety was not defined, implemented, and maintained.</p> <p>3. Review of the facility's Performance Improvement Plan and 2013/2014 minutes indicated it did not include contracted services: Pharmacy, Biohazard Waste, Laundry, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, and Dietetic Services and did not include monitoring the following internal services: Medical Records. Laundry (Behavioral</p>		<p>annual basis.</p> <p>On or before 11/12/14, Hamilton's Organizational Improvement and Corporate Compliance staff will communicate with key contacts from all internal and contracted Hospital services to clarify expectations regarding the designation and establishment of quality and performance indicators for each service area, expectations for the reporting of monitoring data on a quarterly basis, or more frequently as indicated, and as needed, expectations for collaboration in the evaluation of performance data and implementation of performance improvement initiatives.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the renewed activities and expectations as outlined to ensure a comprehensive and focused assessment of the Hospital's Quality and Performance Improvement Program.</p> <p>On 11/19/14, Hamilton's Organizational Improvement and Corporate Compliance staff shall outline a reporting schedule and process flow to ensure that relevant information is being reported and, as indicated, acted upon through appropriate</p>	

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	<p>Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency.</p> <p>4. At 10:15 AM on 10/7/2014, staff member #4 (Executive Director of Quality Improvement) confirmed contracted services: Pharmacy, Biohazard Waste, Laundry, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, and Dietetic Service Services and non-contracted services: Medical Records, Laundry (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services, and Psychiatric Emergency were not part of the hospital's comprehensive quality assessment and improvement (QA&I) program.</p> <p>5. At 10:30 AM on 10/8/2014, staff member #2 (Chief Medical Officer) confirmed that the hospital was not specific on monitoring all services that affect the hospital.</p>		<p>leadership and committee oversight structures. This reporting schedule and process flow will be implemented with reporting responsibilities beginning with December 2014 reporting schedule.</p> <p>- <u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Quality and Performance Improvement initiatives through the following activities:</p> <ul style="list-style-type: none"> - Hamilton's Organizational Improvement and Corporate Compliance department will monitor data reporting each month to ensure reports are received from all internal and contracted Hospital services, consistent with the established reporting schedule and expectations. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations. - All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director of Organizational Improvement and Corporate Compliance, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall</p>		

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A000309	<p>482.21(e)(1), (e)(2), (e)(5) QAPI 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:</p> <p>1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually.</p> <p>Based on documentation review and staff interview, the Governing Body, Medical Staff and administrative staff failed to assure there was an effective quality improvement and patient safety</p>	A000309	<p>compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p> <p>Tag A309 QAPI Executive Responsibilities</p> <p><u>Corrective Action(s):</u> Hamilton's Board has delegated to its Professional Affairs Committee ("PAC"), on its behalf, functions related to the review of</p>	11/19/2014	

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	<p>program for the hospital that addressed quality improvement and patient safety, including the reduction of medical errors, hospital-wide quality assessment and performance improvement which addresses improved quality of care and patient safety.</p> <p>Findings included.</p> <ol style="list-style-type: none"> 1. The Bylaws of Hamilton Center, Inc did not address how the Governing Body will oversee the quality improvement and patient safety program for the hospital. 2. The 2014 Hamilton Center, Inc Organizational Plan indicated it addresses the the entire organization and not specifically the hospital. The inpatient services of the plan does not have a hospital-wide quality assessment and performance improvement efforts that address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. 		<p>the Quality and Performance Improvement program, including the review and approval of the program for measuring, tracking, and analyzing quality indicators and performance outcomes designed to assess processes of care, Hospital services, and operations. The PAC's responsibility for oversight includes expectations for the program to incorporate quality indicators and performance data from all internal and contracted services, and for the use of data collected to monitor the effectiveness and safety of services and quality of care. The Board has outlined an expectation that the PAC shall periodically review reports from the Quality and Performance Improvement program, and shall review the plan and activities of the Quality and Performance Improvement program on an annual basis.</p> <p>On or before 11/12/14, Hamilton's Organizational Improvement and Corporate Compliance staff will communicate with key contacts from all internal and contracted Hospital services to clarify expectations regarding the designation and establishment of quality and performance indicators for each service area, expectations for the reporting of monitoring data on a quarterly basis, or more frequently as indicated, and as needed,</p>	

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	<p>The ongoing program for quality improvement and patient safety was not defined, implemented, and maintained. This was evidenced by 14 of 14 services not being monitored: Pharmacy, Biohazard Waste, contracted Laundry services, Maintenance, Radiology-Diagnostic, Psychology-Telepsychology, Dietetic Service, Medical Records, internal Laundry Services (Behavioral Health), Security, Alcohol/Drug, Response to Patient Emergency, Social Services and Psychiatric Emergency.</p> <p>3. At 10:30 AM on 10/8/2014, staff member #2 (Chief Medical Officer) confirmed that the hospital was not specific on monitoring all services that affect the hospital.</p>		<p>expectations for collaboration in the evaluation of performance data and implementation of performance improvement initiatives.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the renewed activities and expectations as outlined to ensure a comprehensive and focused assessment of the Hospital's Quality and Performance Improvement Program.</p> <p>On 11/19/14, Hamilton's Organizational Improvement and Corporate Compliance staff shall outline a reporting schedule and process flow to ensure that relevant information is being reported and, as indicated, acted upon through appropriate leadership and committee oversight structures. This reporting schedule and process flow will be implemented with reporting responsibilities beginning with December 2014 reporting schedule.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Quality and Performance Improvement initiatives through the following activities:</p>				

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A000338	<p>482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. Based on document review and staff interview, it was determined that the Medical Staff failed to</p>	A000338	<p>Hamilton's Organizational Improvement and Corporate Compliance department will monitor data reporting each month to ensure reports are received from all internal and contracted Hospital services, consistent with the established reporting schedule and expectations. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations.</p> <p>All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director of Organizational Improvement and Corporate Compliance, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p> <p>Tag A 338 Medical Staff</p> <p><u>Corrective Action(s):</u> Hamilton's response and Plan of Correction ("POC") for</p>	11/19/2014

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	<p>ensure written Medical Staff bylaws and Medical Staff Rules and Regulations for effectively carrying out its responsibilities for the conduct of the hospital. The facility failed to provide Medical Staff Periodic Appraisals by its members (see A 340), failed to ensure Medical Staff Credentialing Process (see A 341), failed to ensure Medical Staff bylaws (see A 353) failed to ensure the Governing Board has approved the Medical Staff bylaws (see A 354), failed to approve written Medical Staff bylaws that describe the privileging process to be used by the hospital (see A 355), failed to have an Organization of the Medical Staff (see A 356), failed to define the Medical Staff Qualifications (see A 357) and failed to have written criteria for Medical Staff privileging (see A 363).</p> <p>The cumulative effect of these systematic problems resulted in the hospital's inability to ensure an</p>		<p>Tag A 338 is outlined below in Hamilton's response and POCs for each of the following: Tag A 340, Tag A 341, Tag A 353, Tag A 354, Tag A 355, Tag A356, Tag A357 and Tag A 363. The details of the respective POCs are incorporated by reference and collectively represent the POC for Tag A 338.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	

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A000340	<p>effective Medical Staff that is legally responsible for the conduct of the hospital.</p> <p>482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members. Based on documentation review and staff interview, the Medical Staff failed to conduct periodical review of its members for 7 of 7 physicians (M1, M2, M3, M4, M5, M6, and M7).</p> <p>Findings included:</p> <p>1. The seven Medical Staff employees performance evaluations were signed and approved by Human Resource Division. The evaluations lacked documentation the Medical Staff conducted periodic appraisals of staff M1, M2, M3, M4, M5, M6 and M7. The performance evaluations were not periodical</p>	A000340	<p>Tag A340 Medical Staff Periodic Appraisals</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to</p>	11/19/2014

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	<p>reviews by the members of the Medical Staff.</p> <p>2. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff are not appointed by the Governing Board. Medical staff members are hired by human resources and the CEO has the hiring authority for all Medical Staff.</p>		<p>offer advice and recommendations regarding the various contents, including eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws. During this special meeting, consistent with the Medical Staff Bylaws, Hamilton's Board will also review</p>	

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			<p>and take action related to the applications for membership and privileges of the CMO and the Medical Director for Hospitalist Services.</p> <p>Following the Board's approval of the Medical Staff Bylaws and the granting of membership and privileges for the CMO and Medical Director for Hospitalist Services, the MSEC structure and functions will be formalized and operational, and the MSEC will assume responsibilities for reviewing and recommending actions on the remaining applicants through the Medical Staff process beginning 11/19/14. After requests for initial appointments and clinical privileges have been reviewed, the Medical Staff will perform periodic reappraisals of credentialed practitioners as needed, but no less frequently than every two years consistent with the reappointment process.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical 	

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A000341	<p>482.22(a)(2) MEDICAL STAFF CREDENTIALING The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section.</p> <p>Based on document review and staff interview, the Medial Staff</p>	A000341	<p>Staff Bylaws and Credentialing Policy and Process.</p> <p>Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	11/19/2014	
			Tag A341 Medical Staff Periodic Credentialing		

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	<p>failed to examine credentials of medical staff for medical staff membership and make recommendations to the governing body on appointment of candidates for 7 of 7 medical staff members (M1, M2, M3, M4, M5, M6, and M7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of medical staff M1, M2, M3, M4, M5, M6, and M7's files lacked documentation of the medical staff examining and making recommendation on appointment. 2. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated individuals are hired by Human Resources. The Medical Staff does not have Medical Staff bylaws. 		<p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to</p>		

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			<p>Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process, and specify that Members appointed by the Board are subject to all Medical Staff Bylaws and Hospital policies.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws. During this special meeting, consistent with the Medical Staff Bylaws, Hamilton's Board will also review and take action related to the applications for membership and privileges of the CMO and the Medical Director for Hospitalist Services.</p> <p>Following the Board's approval of the Medical Staff Bylaws and the granting of membership and privileges for the CMO and Medical Director for Hospitalist Services, the MSEC structure and functions will be formalized and operational, and the MSEC will</p>	

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NAME OF PROVIDER OR SUPPLIER HAMILTON CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 620 8TH AVE TERRE HAUTE, IN 47804
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(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>assume responsibilities for reviewing and recommending actions on the remaining applicants through the Medical Staff process beginning 11/19/14.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process. Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	

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A000353	<p>482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: Based on staff interview, the Medical Staff failed to adopt medical staff bylaws for one (1) medical staff.</p> <p>Findings included: At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated there are no Medical Staff bylaws.</p>	A000353	<p>Tag A 353 Medical Staff Bylaws</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including responsibilities for the Medical Staff to adopt and enforce Medical Staff Bylaws.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p>	11/13/2014	

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			<p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for 	

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A000354	<p>482.22(c)(1) APPROVAL OF MEDICAL STAFF BYLAWS [The bylaws must:]</p> <p>(1) Be approved by the governing body. Based on staff interview, the Governing Body failed to approve medical staff bylaws for one (1) medical staff.</p> <p>Findings included:</p> <p>At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated Medical Staff do not have bylaws for the Governing Body to approve.</p>	A000354	<p>any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, and ensure their commitment to abide by the Medical Staff Bylaws and Hospital policies.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 354 Approval of Medical Staff Bylaws</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p>	11/13/2014

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			<p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including responsibilities for the Medical Staff to adopt and enforce Medical Staff Bylaws.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include eligibility requirements and application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a</p>	

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A000355	482.22(c)(2) MEDICAL STAFF PRIVILEGING [The bylaws must:] (2) Include a statement of the duties and		<p>Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, and ensure their commitment to abide by the Medical Staff Bylaws and Hospital policies. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p>	

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	<p>privileges of each category of medical staff (e.g., active, courtesy, etc.)</p> <p>Based on staff interview, the Medical Staff bylaws failed to include a statement of the duties and privileges of each category of medical staff.</p> <p>Findings included:</p> <p>At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated there are no Medical Staff bylaws.</p>	A000355	<p>Tag A 355 Medical Staff Privileging</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including which categories of practitioners are eligible candidates for appointment to the Medical Staff, eligibility requirements, application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process, and the duties and privileges of each category of Medical Staff.</p>	11/13/2014

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			<p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include which categories of practitioners are eligible candidates for appointment to the Medical Staff, eligibility requirements, application/privileging necessary to become a member and/or credentialed practitioner through the Medical Staff process, and the duties and privileges of each category of Medical Staff.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the</p>	

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A000356	<p>482.22(c)(3) ORGANIZATION OF MEDICAL STAFF [The bylaws must:]</p> <p>(3) Describe the organization of the medical staff. Based on staff interview, the Medical Staff failed to ensure bylaws that describe the organization of the Medical Staff.</p>	A000356	<p>following activities:</p> <ul style="list-style-type: none"> Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, and ensure their commitment to abide by the Medical Staff Bylaws and Hospital policies. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 356 Organization of Medical Staff</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners</p>	11/13/2014

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	<p>Findings included:</p> <p>1. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff does not have bylaws.</p>		<p>through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including the organization of the Medical Staff.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include a description of the organization of the Medical Staff.</p>		

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A000357	<p>482.22(c)(4) MEDICAL STAFF QUALIFICATIONS [The bylaws must:]</p> <p>(4) Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.</p>		<p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p>	

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	<p>Based on staff interview, the Medical Staff failed to have Medical Staff bylaws that describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff does not have bylaws.</p>	A000357	<p>Tag A 357 Medical Staff Qualifications</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including which categories of practitioners are eligible candidates for appointment to the Medical Staff, eligibility requirements including selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner, and the application/privileging steps necessary to become a member</p>	11/13/2014			

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			<p>and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include which categories of practitioners are eligible candidates for appointment to the Medical Staff, eligibility requirements including selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner, and the application/privileging steps necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the</p>	

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			<p>Hospital and for the approval of Medical Staff Bylaws. During this special meeting, consistent with the Medical Staff Bylaws, Hamilton's Board will also review and take action related to the applications for membership and privileges of the CMO and the Medical Director for Hospitalist Services.</p> <p>Following the Board's approval of the Medical Staff Bylaws and the granting of membership and privileges for the CMO and Medical Director for Hospitalist Services, the MSEC structure and functions will be formalized and operational, and the MSEC will assume responsibilities for reviewing and recommending actions on the remaining applicants through the Medical Staff process beginning 11/19/14. After requests for initial appointments and clinical privileges have been reviewed, the Medical Staff will perform periodic reappraisals of credentialed practitioners as needed, but no less frequently than every two years consistent with the reappointment process.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p>	

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A000363	482.22(c)(6) CRITERIA FOR MEDICAL STAFF PRIVILEGING [The bylaws must:] Include criteria for determining the privileges		<ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, and ensure their commitment to abide by the Medical Staff Bylaws and Hospital policies. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office staff shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p>		

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(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>to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4).</p> <p>Based on staff interview, the Medical Staff failed to have Medical Staff bylaws that include the criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 10/7/2014, staff member #2 (Chief Medical Officer) indicated the Medical Staff does not have bylaws.</p>	A000363	<p>Tag A 363 Criteria for Medical Staff Privileging</p> <p><u>Corrective Action(s):</u> Hamilton has ensured the provision of patient care services and oversight of physicians and other professional practitioners through employment and contractual relationships. In addition to the existing infrastructure, and in support of the requirement to establish an organized Medical Staff for the Hospital, the CEO facilitated efforts to draft Medical Staff Bylaws based on the advice and recommendations of the existing physicians and practitioners.</p> <p>On 10/19/14, the CMO held a meeting where existing physicians and practitioners with employment or contractual relationships with Hamilton were afforded an opportunity to review draft Medical Staff Bylaws and to offer advice and recommendations regarding the various contents, including which categories of practitioners are</p>	11/13/2014	

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			<p>eligible candidates for appointment to the Medical Staff, eligibility requirements including selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner, and the application/privileging steps necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/7/14, Hamilton's CEO and CMO reviewed and approved a final version of the Medical Staff Bylaws.</p> <p>On 11/10/14, Hamilton's CEO, on behalf of the CMO and existing physicians and practitioners, submitted a recommendation to Hamilton's Board for the approval of the creation of an organized Medical Staff for the Hospital known as "Hamilton Medical Staff" and for the approval and adoption of the Hamilton Medical Staff Bylaws which include which categories of practitioners are eligible candidates for appointment to the Medical Staff, eligibility requirements including selection criteria of individual character, competence, training, experience, and judgment as necessary components to become a member and/or credentialed practitioner, and the application/privileging steps</p>	

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			<p>necessary to become a member and/or credentialed practitioner through the Medical Staff process.</p> <p>On 11/13/14, Hamilton's Board will hold a special meeting to review and take action related to the recommendations for approval of the establishment of a Medical Staff organization for the Hospital and for the approval of Medical Staff Bylaws. During this special meeting, consistent with the Medical Staff Bylaws, Hamilton's Board will also review and take action related to the applications for membership and privileges of the CMO and the Medical Director for Hospitalist Services.</p> <p>Following the Board's approval of the Medical Staff Bylaws and the granting of membership and privileges for the CMO and Medical Director for Hospitalist Services, the MSEC structure and functions will be formalized and operational, and the MSEC will assume responsibilities for reviewing and recommending actions on the remaining applicants through the Medical Staff process beginning 11/19/14. After requests for initial appointments and clinical privileges have been reviewed, the Medical Staff will perform periodic reappraisals of credentialed practitioners as needed, but no less frequently</p>	

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			<p>than every two years consistent with the reappointment process.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, the Board shall ensure oversight of the Hospital's Medical Staff through the following activities:</p> <ul style="list-style-type: none"> · Once approved, the Hamilton Medical Staff Bylaws shall be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Once the Hamilton Medical Staff is established, Hamilton's Board shall require Hamilton's Medical Staff to provide reports and recommendations for any applicants requesting appointment or reappointment consistent with the Medical Staff Bylaws and Credentialing Policy and Process, and ensure their commitment to abide by the Medical Staff Bylaws and Hospital policies. · Prior to each Medical Staff Executive Committee ("MSEC") meeting, Hamilton's HR/Medical Staff Office shall perform audits of all applications for appointment/reappointment to Hamilton's Medical Staff to ensure they are complete and that the practitioners requesting membership and/or privileges are identified within the appropriate category and meet eligibility requirements. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of the respective POC. Hamilton's Governing Board</p>	

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A000458	<p>482.24(c)(4)(i)(A) CONTENT OF RECORD: HISTORY & PHYSICAL All records must document the following, as appropriate: (i) Evidence of-- (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.</p> <p>Based on policy and procedure review, medical record review and interview, the facility failed to follow their policy regarding authentication of history and physicals for 16 of 18 closed records reviewed of patients hospitalized for over 48 hours (N2- N7, N11, N12, N14, and N16- N22).</p> <p>Findings included:</p> <p>1. The facility policy "Physical Exams", last reviewed 07/14, indicated, "1. A physical assessment will be completed, within twenty-four (24) hours of admission, by the attending psychiatrist,</p>	A000458	<p>maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p> <p>Tag A 458 Content of Record: History & Physical</p> <p><u>Corrective Action(s):</u> - On 11/10/14, Hamilton's policy "Physical Exams" was revised to reflect expectations consistent with the requirement that a History & Physical be completed, documented, and available in the patient's medical record within 24 hours after admission, including appropriate authentication by the performing practitioner. Additionally, if performed by an Allied Health Practitioner, appropriate physician countersignature must be completed by 30 days following</p>	11/19/2014

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	<p>Nurse Practitioner, or family practice physician. ...4. A copy of the dictated physical examination will be placed on the chart within 48 hours of admission for review and signature by the physician.</p> <p>5. The signature of the attending psychiatrist, family nurse practitioner, or the family practice physician must be obtained within 48 hours of admission."</p> <p>2. The medical record for patient N2 indicated an admission on 08/20/14 with a history and physical (H & P) completed by the nurse practitioner on 08/21/14, but not authenticated until 08/27/14.</p> <p>3. The medical record for patient N3 indicated an admission on 08/19/14 with an H & P completed by the nurse practitioner on 08/20/14, but not authenticated until 08/26/14.</p> <p>4. The medical record for patient N4 indicated an admission on 07/26/14 with an H & P completed by the nurse practitioner on 07/27/14, but not authenticated until 08/09/14.</p> <p>5. The medical record for patient N5 indicated an admission on 08/20/14 with an H & P completed by the nurse practitioner on 08/21/14, but not authenticated until 08/27/14.</p>		<p>discharge.</p> <p>This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14.</p> <p>All practitioners who perform and document History & Physicals for the Hospital's patients will receive re-education and reinforcement of expectations on or before 11/19/14.</p> <p><u>Monitoring:</u> To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's "Physical Exams" policy will be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · For an initial 90-day monitoring period, all medical records for Hospital inpatients will be reviewed daily for compliance with expectations for the completion and documentation of History & Physicals, including indicated authentication, within 24 hours after admission. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations. · Following the initial 90-day monitoring period, History & Physicals will be included with other indicators for review through established auditing programs. 				

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	<p>6. The medical record for patient N6 indicated an admission on 08/21/14 with an H & P completed by the nurse practitioner on 08/22/14, but not authenticated until 08/26/14.</p> <p>7. The medical record for patient N7 indicated an admission on 08/14/14 with an H & P completed by the nurse practitioner on 08/15/14, but not authenticated until 08/26/14.</p> <p>8. The medical record for patient N11 indicated an admission on 09/04/14 with an H & P completed by the nurse practitioner on 09/05/14, but not authenticated until 09/09/14.</p> <p>9. The medical record for patient N12 indicated an admission on 09/08/14 with an H & P completed by the nurse practitioner on 09/09/14, but not authenticated.</p> <p>10. The medical record for patient N14 indicated an admission on 08/20/14 with an H & P completed by the nurse practitioner on 08/21/14, but not authenticated until 08/27/14.</p> <p>11. The medical record for patient N16 indicated an admission on 08/26/14 with an H & P completed by the nurse practitioner on 08/27/14, but not</p>		<p>All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures.</p> <p><u>Responsible Person(s):</u> Hamilton's CMO is responsible for the implementation and has ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>				

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	<p>authenticated until 09/02/14.</p> <p>12. The medical record for patient N17 indicated an admission on 08/15/14 with an H & P completed by the nurse practitioner on 08/16/14, but not authenticated until 09/05/14.</p> <p>13. The medical record for patient N18 indicated an admission on 08/12/14 with an H & P completed by the nurse practitioner on 08/13/14, but not authenticated until 08/27/14.</p> <p>14. The medical record for patient N19 indicated an admission on 08/28/14 with an H & P completed by the nurse practitioner on 08/29/14, but not authenticated until 09/02/14.</p> <p>15. The medical record for patient N20 indicated an admission on 08/27/14 with an H & P completed by the nurse practitioner on 08/28/14, but not authenticated until 09/02/14.</p> <p>16. The medical record for patient N21 indicated an admission on 08/15/14 with an H & P completed by the nurse practitioner on 08/16/14, but not authenticated until 09/05/14.</p> <p>17. The medical record for patient N22 indicated an admission on 09/01/14 with</p>				

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A000469	<p>an H & P completed by the nurse practitioner on 09/02/14, but not authenticated until 09/11/14.</p> <p>18. At 4:20 PM on 10/07/14, staff member A3, the Vigo County Services Director, who navigated the EMR (Electronic Medical Records) confirmed the H & Ps were not authenticated within 48 hours according to facility policy.</p> <p>482.24(c)(2)(viii) CONTENT OF RECORD: FINAL DIAGNOSIS [All records must document the following, as appropriate:]</p> <p>Final diagnosis with completion of medical records within 30 days following discharge Based on medical record review and interview, the facility failed to ensure all medical records were completed within 30 days of discharge for 9 of 18 closed records reviewed of patients hospitalized for over 48 hours (N1, N2, N3, N5, N7, N12, N14, N18, and N19).</p> <p>Findings included:</p> <p>1. The medical record for patient N1 indicated an admission on 08/30/14 and a discharge on 09/02/14 with the dictated History & Physical (H & P) not</p>	A000469	<p>Tag A 469 Content of Record: Final Diagnosis</p> <p><u>Corrective Action(s):</u></p> <p>- On 11/10/14, Hamilton's policy "Physical Exams" was revised to reflect expectations consistent with the requirement that a History & Physical be completed, documented, and available in the patient's medical record within 24 hours after admission, including appropriate authentication by the performing practitioner. Additionally, if performed by an Allied Health Practitioner,</p>	11/19/2014

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	<p>countersigned by the physician until 10/05/14.</p> <p>2. The medical record for patient N2 indicated an admission on 08/20/14 and a discharge on 08/25/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>3. The medical record for patient N3 indicated an admission on 08/19/14 and a discharge on 08/28/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>4. The medical record for patient N5 indicated an admission on 08/20/14 and a discharge on 08/26/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>5. The medical record for patient N7 indicated an admission on 08/14/14 and a discharge on 08/20/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>6. The medical record for patient N12 indicated an admission on 09/08/14 and a discharge on 09/15/14 with the dictated H & P not signed by the nurse practitioner or countersigned by the physician.</p> <p>7. The medical record for patient N14</p>		<p>appropriate physician countersignature must be completed by 30 days following discharge.</p> <p>This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14.</p> <p>All practitioners who perform and document History & Physicals for the Hospital's patients will receive re-education and reinforcement of expectations on or before 11/19/14.</p> <p>- <u>Monitoring:</u> To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's "Physical Exams" policy will be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · For an initial 3-month monitoring period, all medical records for discharged Hospital inpatients will be reviewed on a monthly basis for compliance with expectations for documentation of History & Physicals, including indicated countersignatures, within 30 days following discharge. If gaps are identified, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations. · Following the initial 90-day monitoring period, History & Physicals will 	

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A000749	<p>indicated an admission on 08/20/14 and a discharge on 08/22/14 with the dictated H & P not countersigned by the physician until 09/24/14.</p> <p>8. The medical record for patient N18 indicated an admission on 08/12/14 and a discharge on 08/21/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>9. The medical record for patient N19 indicated an admission on 08/28/14 and a discharge on 08/31/14 with the dictated H & P not countersigned by the physician until 10/05/14.</p> <p>10. At 4:20 PM on 10/07/14, staff member A3, the Vigo County Services Director, who navigated the EMR (Electronic Medical Records) confirmed the H & Ps were not countersigned by the physician within 30 days after discharge as required. He/she could not provide written documentation of this requirement by the facility, but indicated it was the expectation.</p> <p>482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting,</p>		<p>be included with other indicators for review through established auditing programs.</p> <p>All monitoring results will be communicated through the MSEC and Quality/Organizational Improvement monitoring structures.</p> <p><u>Responsible Person(s):</u> Hamilton's CMO is responsible for the implementation and has ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>		

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	<p>investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>Based on document review, personnel file review, policy and procedure, observation and interview, the infection control officer failed to monitor staff immunization status for designated infectious diseases, as recommended by the CDC for 31 of 31 employees (A1, A2, A4, A5, A6, A7, A8, A9, A10, A11, A12, A13, A14, A16, A19, A20, N1, N2, N3, N4, N5, N6, N8, N9, N10, N11, N12, N13, N14, N15, and N16) and failed to ensure a safe environment for patients, staff and visitors by ensuring proper chemical use and proper cleaning of laundry equipment between patients.</p> <p>Findings:</p> <p>1. Hamilton Center, Inc Environment of Care Manual Consumer Health policy (last reviewed Sept 2014) stated, "To protect consumers, staff and the</p>	A000749	<p>Tag A 749 Infection Control Program <u>Corrective Action(s)</u>: Hamilton's Infection Control Officer has reviewed and modified Hamilton's system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel by incorporating the following activities: (A) Immunization/Immunity Status · Consistent with the CDC's recommendations, Hamilton has developed new policies and procedures to facilitate the adoption of expectations surrounding monitoring the immunization and/or immunity status of health care personnel for Varicella, Measles, Mumps and Rubella. · This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14. · All of Hamilton's employees and practitioners received notice of the new policy expectations through Hamilton's internal communication system on 11/7/14. By 11/24/14, all staff born on or after January 1, 1957 are requested to provide evidence of immunization or immunity consistent with the acceptable documentation</p>	12/24/2014

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	<p>Hamilton Center, Inc (HCI) environment through the prevention and control of infections and infestations and the prevention and/or reduced transmission of health care-acquired infections. HCI adheres to rules, regulations and guidelines established by the U.S. Centers for Disease Control and Prevention (CDC) and the Indiana State Department of Health."</p> <p>2. Center for Disease Control (CDC) recommended that all Healthcare personnel (HCP) be immune to Varicella. Evidence of Immunity in HCP includes documentation of varicella vaccine given, history of varicella based on physician diagnosis, laboratory evidence of immunity, or laboratory confirmation of disease. HCP who work in medical facilities should be immune to measles, mumps, and rubella. The HCP can be considered immune to measles, mumps, and rubella only if they have documentation of a</p>		<p>requirements as outlined. For any required staff who are unable to provide sufficient documentation or where immunity cannot be confirmed by 11/24/14, Hamilton has outlined procedures to be followed that provide options for ways for them to obtain the indicated vaccinations and to provide the required documentation. Documentation should be received by Hamilton for all of the applicable Hospital Health Care Personnel on or before 12/24/14. Documentation should be received by Hamilton for all other Hospital Personnel on or before 1/5/15. <u>Monitoring:</u> -</p> <ul style="list-style-type: none"> · To ensure compliance on an ongoing basis, Hamilton will implement the following activities: · On an ongoing basis, human resources will begin requiring proof of immunization status post offer/pre-hire beginning 11/10/2014/ Proof of immunization status will be retained in the employees health file. · Infection Control Officer will report to the ICEH committee and Human Resources immunization status of new and current employees on a quarterly basis to ensure immunization compliance. · ICEH officer will notify employee and employee supervisor when the employee immunization status requires an update. <u>Responsible Party:</u> Infection Control Employee Health Officer and Human Resource Department. <u>Date of</u> 	

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	<p>physician diagnosed measles or mumps disease; or laboratory evidence of measles, mumps, or rubella immunity or appropriate vaccination against measles, mumps, and rubella.</p> <p>3. Review of the hospital's staff health records indicated that 31 of 31 personnel records did not show documented evidence of immunization of Rubella, Rubeola, and Varicella (A1, A2, A4, A5, A6, A7, A8, A9, A10, A11, A12, A13, A14, A16, A19, A20, N1, N2, N3, N4, N5, N6, N8, N9, N10, N11, N12, N13, N14, N15, and N16). However, staff member A14 had documented evidence of immunization of Rubella and Rubeola only.</p> <p>4. At 10:00 AM on 10/8/2014, staff member #15 (Administrative Assistant) confirmed that there was no documented evidence in the 31 employee files that were reviewed confirming immunization of Rubella, Rubeola, and Varicella.</p>		<p><u>Completion: 12/24/2014(B)</u> Disinfection/Laundry Services · Hamilton reviewed and revised its policies and procedures on 11/1/14 to ensure: (1) they reflect and appropriately reference applicable expectations and disinfectants presently approved for use in the Hospital; (2) expectations for staff's mixing and use of disinfectants according to manufacturer's guidelines; and (3) requirements for disinfection of laundry facilities in between each patient's personal use in the Hospital setting. · Appropriate measuring devices were purchased and were stocked within the appropriate environmental/housekeeping dilution areas of the Hospital for use with mixing/diluting cleaning chemicals/disinfectants. These were stocked and ready for use on 11/3/14. · All impacted Hospital environmental/housekeeping staff received re-education and reinforcement of expectations related to the proper dilution of disinfectants and other chemicals, including expectations for the use of proper measuring devices and for ensuring dilution ratios consistent with manufacturer's guidelines. Education/training was completed by 11/3/14. · All impacted Hospital Health Care Personnel who support the inpatient operations shall receive</p>				

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	<p>5. Beginning at 9:00 AM on 10/08/14, the inpatient unit was toured with staff members A3, the Vigo County Services Director, A10, the Director of 24-hr. Services, and A14, the Director of Nursing, and two stackable washer/dryer units were observed in a small, open room. The environmental services room was observed with cleaning supplies, equipment, and the disinfectant NABC, but no measuring devices were observed.</p> <p>6. The facility policy "Laundry Care", last reviewed 09/14, indicated, "A. Hamilton Center, Inc. shall implement laundry procedures that prevent cross contamination and reduce occupational exposure based on Occupational Safety and Health Administration (OSHA) and Joint Commission of Accreditation of Healthcare Organizations (JCAHO) standards that emphasize hygienic handling, processing, and storage of laundry and staff's use of Universal Precautions. ...C. Hamilton Center, Inc. provides laundry equipment for consumer use in Inpatient Services, Child & Adolescent Services, Rehabilitation Services, and all residential services. Each service area is responsible for implementing procedures that comply with the following policy components for use in their respective program/service area. ...Special Precautions: 10.</p>		<p>education and training related to expectations related to the safe storage and handling of chemicals/disinfectants and expectations for disinfecting the Hospital laundry facilities. Education/training will be completed on or before 11/14/14.</p> <ul style="list-style-type: none"> · These revised policies and procedures will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14. · The following steps will be taken to further facilitate and support requirements for disinfection of the Hospital's laundry facilities in between each patient's personal use: (1) Patient laundry hours will be modified to specify a limitation on a patient's access to laundry facilities. New laundry hours will be posted in the Hospital inpatient laundry area and will be 7:00am - 7:00pm; (2) A sign outlining requirements that laundry facilities must be disinfected between each patient's personal use will be conspicuously posted within the Hospital inpatient laundry area; (3) Unit rules will outline responsibilities and expectations related to personal laundry and use of the Hospital's laundry facilities; and (4) A laundry facility disinfection chart will be utilized by staff to document completion of disinfection duties on an ongoing basis. All of 	

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	<p>Consumer and facility laundry shall not be washed together. 11. Consumers clothes shall not be washed together."</p> <p>7. The facility policy "Exposure Control Plan Methods of Ensuring Compliance", last reviewed 04/14, indicated, "III. A. Hamilton Center, Inc. Housekeeping Controls: The Facilities Manager and Housekeeping Supervisor are responsible for developing, implementing, and supervising a written schedule for cleaning and decontamination of the various areas of the Center. The schedule specifies the day and time of work and also the following information: 1. The area to be cleaned/decontaminated. 2. Cleansers and disinfectants to be used."</p> <p>8. Manufacturer's label directions on the NABC disinfectant indicated the proper dilution for cleaning and disinfection was 1:10 or 12 ounces of chemical to each gallon of water.</p> <p>9. At 10:00 AM on 10/08/14, staff member A10 indicated the patients/consumers washed their own clothes in the washer/dryer, but he/she was unsure of the cleaning process.</p> <p>10. At 10:15 AM on 10/08/14, staff member A23, the Environmental Services Supervisor, indicated the NABC</p>		<p>these additional steps will be completed on or by 11/19/14.</p> <p><u>Monitoring:</u> Disinfection/Laundry Services: · For an initial 90-day monitoring period, the laundry facility disinfection chart will be monitored on a weekly basis for compliance with expectations for disinfection. Additionally, during the initial 90-day monitoring period, a weekly audit will be performed of environmental/housekeeping dilution activities to ensure proper use of measuring devices and dilution according to manufacturer guidelines. If gaps are identified in either process, immediate remedial measures will be implemented to correct any identified variances in practice and to reinforce expectations. · Following the initial 90-day monitoring period, monitoring for compliance with laundry facility disinfection requirements and with proper dilution and use of disinfectants will be included with other indicators for review through established auditing programs. · All monitoring results will be communicated through the established Infection Prevention and Quality/Organizational Improvement monitoring structures. <u>Responsible Person(s):</u> Hamilton's Infection Control Officer is responsible for the implementation and has ultimate responsibility for ensuring overall compliance. <u>Date</u></p>	

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	<p>disinfectant was the product used for cleaning and mopping on the unit. He/she indicated he/she thought the disinfectant was run through the wash cycle daily.</p> <p>11. At 10:30 AM on 10/08/14, staff members A24 and A25, two environmental services staff members who cleaned the unit, arrived to put supplies away, and were interviewed. They indicated they mixed about two ounces of chemical to each gallon of water, but confirmed they did not use any measuring device. When questioned regarding the amount of chemical they used for the each task, they indicated they put one capful of disinfectant into the small three liter bucket and filled with water to hold their rags to clean surfaces and put one and one-half capfuls into the five gallon bucket for mopping. (The capful referred to was the lid on the disinfectant which was approximately one-half an ounce.) Staff members A24 and A25 indicated they wiped the washer/dryer units with disinfectant daily and ran a wash cycle with disinfectant once a week. They indicated they did not use bleach on the unit because the smell bothered some of the patients.</p> <p>12. At 12:20 PM on 10/08/14, staff member A13, the Infection Control</p>		of Completion: 11/19/2014		

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	<p>Nurse, indicated Environment of Care rounds were performed quarterly with staff from Infection Control, Environmental Services, and Facilities Management, but confirmed there was no actual observation or monitoring of the cleaning staff or procedures. He/she confirmed there was no specific laundry policy to ensure proper disinfection between patients.</p> <p>13. At 12:50 PM on 10/08/14, staff member A23 indicated all of the cleaning staff received a 3-day orientation and annual inservicing and were good about communicating and asking staff if they had any questions or concerns. He/she confirmed he/she did not actually observe the staff mixing chemicals and also confirmed the laundry policy was unclear. Staff member A23 provided documentation of cleaning checklists, dilution ratios, and a wet mopping procedure which indicated two ounces (1/4 cup) of Quat [disinfectant] should be put in the mop bucket. The procedure did not indicate how much water should be in the bucket and staff member A23 indicated Quat was not the chemical in use anymore.</p>						

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A000884	<p>482.45 ORGAN, TISSUE, EYE PROCUREMENT Organ, Tissue and Eye Procurement Based on document review and staff interview, it was determined that the hospital failed to ensure a written agreement with an Organ Procurement Organization and Tissue and Eye Bank Agreements which are effective in carrying out its responsibilities for the conduct of the hospital. The facility failed to provide written policies and procedures (see A885), failed to have a written agreement with an Organ Procurement Organization (see A886), failed to have written Tissue and Eye Bank Agreements (see A887), failed to have a designated Requestor (see A889) and failed to educate staff in Organ Procurement (see A891).</p> <p>The cumulative effect of these systematic problems resulted in an inability to ensure an effective organ procurement program that is legally responsible for the conduct</p>	A000884	<p>Tag A 884 Organ, Tissue, & Eye Procurement</p> <p><u>Corrective Action(s):</u> Hamilton's response and Plan of Correction ("POC") for Tag A 884 is outlined below in Hamilton's response and POCs for each of the following: Tag A 885, Tag A 886, Tag A 887, Tag A 889, and Tag A 891. The details of the respective POCs are incorporated by reference and collectively represent the POC for Tag A 884.</p> <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, CEO and Board are collectively responsible for the implementation and ongoing oversight of the respective POCs. Hamilton's Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/13/14</p>	11/13/2014

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A000885	<p>of the hospital.</p> <p>482.45(a) WRITTEN POLICIES AND PROCEDURES The hospital must have and implement written protocols that: Based on staff interview, the hospital failed to ensure written policies and procedures to address its organ procurement responsibilities.</p> <p>Findings included: At 2:00 PM on 10/6/2014, staff member #2 (Chief Medical Officer) indicated the hospital does not have written procedures to address its organ procurement responsibilities.</p>	A000885	<p>Tag A 885 Written Policies & Procedures</p> <p><u>Corrective Action(s):</u></p> <p>On 10/14/14, Hamilton entered into a service agreement with the Indiana Organ Procurement Organization ("IOPO") surrounding expectations and processes to support organ donation and procurement.</p> <p>On 11/10/14, a Hospital policy was drafted titled "Organ, Tissue, & Eye Donation" to provide guidance to staff related to organ procurement responsibilities. This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14.</p> <p>All impacted staff and practitioners currently employed will receive education about this</p>	11/19/2014			

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			<p>policy on or before 11/19/14. Education about this policy and supporting information will be added to new staff orientation for relevant staff on an ongoing basis.</p> <p>- <u>Monitoring:</u></p> <p>- To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's "Organ, Tissue & Eye Donation" policy will be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · As indicated, Hamilton shall review and track any patient deaths of Hospital inpatients for appropriate referral to IOPO for evaluation and consideration for the organ donation process. · Hamilton will incorporate performance monitoring activity for this contractor relationship into existing Medical Staff and Quality/Organizational Improvement activities on an ongoing basis. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director for Organizational Improvement and Corporate Compliance, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of this plan. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p>	

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A000886	<p>482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; Based on staff interview, the hospital failed to have a written agreement with an Organ Procurement Organization.</p> <p>Findings included</p> <p>At 12:45 PM on 10/6/2014, staff member #3 (Vigo County Director) indicated the hospital does not have any written agreement with an Organ Procurement Organization.</p>	A000886	<p><u>Date of Completion:</u> 11/19/14</p> <p>Tag A 886 OPO Agreement</p> <p>- <u>Corrective Action(s):</u></p> <p>On 10/14/14, Hamilton entered into a service agreement with the Indiana Organ Procurement Organization ("IOPO") surrounding expectations and processes to support organ, tissue, and eye donation and procurement.</p> <p>- <u>Monitoring:</u></p> <p>- To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> Hamilton's agreement with IOPO will be reviewed and monitored as needed to ensure provisions remain relevant, applicable and compliant with regulatory requirements. 	11/19/2014	

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A000887	<p>482.45(a)(2) TISSUE AND EYE BANK AGREEMENTS Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;</p> <p>Based on staff interview, the hospital failed to ensure an agreement with a tissue bank and eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues</p>	A000887	<p>· Hamilton will incorporate performance monitoring activity for this contractor relationship into existing Medical Staff and Quality/Organizational Improvement activities on an ongoing basis.</p> <p>- <u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director for Organizational Improvement and Corporate Compliance, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of this plan. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p> <p>Tag A 887 Tissue and Eye Bank Agreement</p> <p>- <u>Corrective Action(s):</u> On 10/14/14, Hamilton entered into a service agreement with the Indiana Organ Procurement Organization ("IOPO")</p>	11/19/2014

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A000889	<p>and eyes.</p> <p>Findings included:</p> <p>At 3:15 PM on 10/6/2014, staff member #2 (Chief Medical Officer) indicated the hospital does not have any agreements with tissue and eye banks.</p> <p>482.45(a)(3) DESIGNATED REQUESTOR The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a</p>		<p>surrounding expectations and processes to support organ, tissue, and eye donation and procurement.</p> <p>- <u>Monitoring:</u></p> <p>- To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's agreement with IOPO will be reviewed and monitored as needed to ensure provisions remain relevant, applicable and compliant with regulatory requirements. · Hamilton will incorporate performance monitoring activity for this contractor relationship into existing Medical Staff and Quality/Organizational Improvement activities on an ongoing basis. <p>- <u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director for Organizational Improvement and Corporate Compliance, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of this plan. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	

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	<p>designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation.</p> <p>Based on documentation review and staff interview, the hospital failed to ensure at least one staff member was trained in the methodology for approaching potential donor families.</p> <p>Findings included:</p> <ol style="list-style-type: none"> All staff personnel (M1 through M7, physicians; AH1 through AH10, nurse practitioners; A1, A2, A4 through A14, A16, A19, A20, non-nursing personnel; N1 through N6, N8 through N12, N14 through N16, nursing personnel) training files were reviewed and none of the staff training documentation addressed methodology for approaching potential donor families. At 12:45 PM on 10/6/2014, staff member #3 (Vigo County 	A000889	<p>Tag A 889 Designated Requestor</p> <p><u>Corrective Action(s):</u></p> <p>On 10/14/14, Hamilton entered into a service agreement with the Indiana Organ Procurement Organization ("IOP") surrounding expectations and processes to support organ, tissue and eye donation and procurement.</p> <p>On 11/10/14, a Hospital policy was drafted titled "Organ, Tissue, & Eye Donation" to provide guidance to staff related to organ procurement responsibilities. This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14.</p> <p>All impacted staff and practitioners currently employed will receive education about this policy on or before 11/19/14. Education about this policy and supporting information will be added to new staff orientation for relevant staff on an ongoing</p>	11/19/2014

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(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	
A000891	482.45(a)(5) STAFF EDUCATION Ensure that the hospital works cooperatively with the designated OPO, tissue bank and		<p>basis.</p> <p>- <u>Monitoring:</u></p> <p>- To ensure compliance on an ongoing basis, Hamilton will implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's "Organ, Tissue & Eye Donation" policy will be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · As indicated, Hamilton shall review and track any patient deaths of Hospital inpatients for appropriate referral to IOPO for evaluation and consideration for the organ donation process. · Hamilton will incorporate performance monitoring activity for this contractor relationship into existing Medical Staff and Quality/Organizational Improvement activities on an ongoing basis. <p><u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director for Organizational Improvement and Corporate Compliance, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of this plan. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>		

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	<p>eye bank in educating staff on donation issues;</p> <p>Based on staff interview, the hospital failed to work cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 12:45 PM on 10/6/2014, staff member #3 (Vigo County Director) indicated the hospital does not have any written agreement with an Organ Procurement Organization. At 2:00 PM on 10/6/2014, staff member #2 (Chief Medical Officer) indicated the hospital does not have written procedures to address its organ procurement responsibilities and staff are not trained on organ procurement issues. 	A000891	<p>Tag A 891 Staff Education</p> <p>- <u>Corrective Action(s):</u></p> <p>On 10/14/14, Hamilton entered into a service agreement with the Indiana Organ Procurement Organization ("IOPO") surrounding expectations and processes to support organ, tissue and eye donation and procurement.</p> <p>On 11/10/14, a Hospital policy was drafted titled "Organ, Tissue, & Eye Donation" to provide guidance to staff related to organ procurement responsibilities. This policy will be reviewed and approved by the CEO and CMO on or before 11/12/14, with a recommendation for approval submitted to the Board during to the special Board meeting on 11/13/14.</p> <p>All impacted staff and practitioners currently employed will receive education about this policy on or before 11/19/14. Education about this policy and supporting information will be added to new staff orientation for relevant staff on an ongoing basis.</p> <p>- <u>Monitoring:</u></p> <p>- To ensure compliance on an ongoing basis, Hamilton will</p>	11/19/2014

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			<p>implement the following activities:</p> <ul style="list-style-type: none"> · Hamilton's "Organ, Tissue & Eye Donation" policy will be reviewed and revised as needed but shall be scheduled for review at least on a triennial basis. · Hamilton will incorporate performance monitoring activity for this contractor relationship into existing Medical Staff and Quality/Organizational Improvement activities on an ongoing basis. <p>- <u>Responsible Person(s):</u> Hamilton's Medical Staff, Executive Director for Organizational Improvement and Corporate Compliance, CEO and Governing Board are collectively responsible for the implementation and ongoing oversight of this plan. Hamilton's Governing Board maintains ultimate responsibility for ensuring overall compliance.</p> <p><u>Date of Completion:</u> 11/19/14</p>	