

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151332	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/26/2013
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NAME OF PROVIDER OR SUPPLIER  DECATUR COUNTY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 720 N LINCOLN ST GREENSBURG, IN 47240
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004714</p> <p>Survey Date: 6-24/26-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 07/01/13</p>	S000000		

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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S000270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 2 contracted services (dental and massage therapy).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the contracted services of dental and massage therapy.</li> <li>In interview, on 6-26-13 at 3:45 pm, employee #A7 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000270	S 0270The deficiency has been corrected on 7/16/13. The PI Projects for Massage Therapy and Dental services have been added to the agenda for our next quarterly Board Quality Committee meeting and follow up at the next Board of Directors meeting. The Director of Quality and Accreditation will prevent the deficiency from recurring by monitoring the data.	07/16/2013			

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S000278	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to ensure that surgeons perform surgical procedures which surgeons were granted privileges in 1 instance (MD #3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the Surgery Schedule dated 06-25-13 indicated that MD #3 performed a fusion of the right knee.</li> <li>2. Review of MD #3's surgical privileges lacked documentation that the governing board had granted privileges to perform a</li> </ol>	S000278	S 0278 The deficiency was corrected on 7/10/2013. The Director and/or Assistant of Surgery will review each surgery case to ensure the physician has appropriate privileges in place. When a discrepancy is found, the Director and/or Assistant of Surgery will inform surgeon of findings. If a discrepancy is found, the case would either be cancelled or another physician with the correct privileges would assist with the surgery if the physician does not have the privileges for the case in question. The Director and/or Assistant of Surgery will complete an incident report. To ensure this deficiency does not recur in the future, the	07/10/2013

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	<p>right knee fusion.</p> <p>3. On 06-25-13 at 1155 hours, staff #42 confirmed that MD #3 privileging file lacked documentation that MD #3 had been granted privileges to perform knee fusion procedures.</p>		<p>hospital will review and update all surgeon privileges to ensure appropriate privileges are in place. Reappointments will be completed in November 2013. The Director and/or Assistant of Surgery will be responsible for ensuring all surgery procedures for each surgeon has the appropriate privileges.</p>	

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR), in accordance with current standards of practice and hospital policy for 1 of 5 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a policy entitled Medical Staff Policy: ISDH Requirements for Medical Staff Membership, effective 12-18-2012, indicated the physician's file shall include C.P.R.[cardiopulmonary resuscitation]/B.L.S.[basic life safety] every two years for Medical staff members providing care in ED, DCPC</p>	S000318	<p>S 0318The medical staff policy titled "ISDH Requirements for Medical Staff Membership" has been revised to indicate the hospital and medical staff standard for BLS for all physicians (see attached updated policy). The Administrative Assistant will monitor the physicians monthly for BLS certification to ensure the deficiency does not recur. On July 25, 2013 the VP of Patient Care revised the Medical Staff Membership policy. On August 7, the revisions to the ISDH Requirements for Medical Staff Membership policy will be reviewed and approved at the Medical Executive Committee (MEC). All physicians will be</p>	11/25/2013

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	<p>(employed physicians), Anesthesia and Cardiopulmonary. Exception: Physicians practicing via telemedicine.</p> <p>3. Review of the above policy did not indicate what the hospital or medical staff standard was for C.P.R./B.L.S. for physicians other than the above-indicated members. Therefore, the other physicians are required to have CPR in accordance with current standards of practice; i.e. C.P.R., B.L.S., PALS (pediatric advanced life support), etc.</p> <p>4. Review of 5 physicians credential files indicated MD#1, an orthopedic surgeon, did not have any documentation of current competency of CPR in accordance with current standards of practice.</p> <p>5. In interview, on 6-26-13 at 11:30 am, employee #A7 confirmed the above and no further documentation was provided prior to exit.</p>		<p><b>notified of the new BLS policy requirement at the next scheduled full medical staff meeting on August 16, 2013. Phase ending 9/25/13: The Administrative Assistant will follow up with any physician who has not complied with the new BLS policy requirement. Phase ending 10/25/13: The Administrative Assistant will follow up with any physician who has not complied with the new BLS policy requirement. Any physician who refuses or does not comply will be reported to the MEC. Phase ending 11/25/2013: The Administrative Assistant will continue to keep the MEC apprised of any physician that falls out of compliance with the new policy requirement. At this point, it will be the responsibility for the MEC to bring the physician into compliance.</b></p>		

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S000320	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.</p> <p>Based on document review and interview, the facility failed to ensure that the employee health inventories were reviewed by designated staff for 4 of 10 personnel files reviewed (N3, N5, N7 and N9).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Infection Prevention: Employee Health Program indicated the following; "Policy: The employee health program includes an initial health inventory and evaluation, with yearly PPD screening and flu vaccine opportunity, and exposure follow up as outlined, as well as identifying infection risks and instituting appropriate prevention measures. Procedure: 1. Employment - Employment evaluation</p>	S000320	<p>S 0320 The Infection Control Committee met on July 12, 2013. The committee delegated the responsibility of determining if a new employee requires a physical examination to the Infection Control Nurse. The health history form will be revised to include triggers that will identify which employees may need a physical examination. The HR Director and the Infection Control Nurse will work with the Medical Director of the Occupational Health and Infection Prevention service to identify these triggers. The Infection Control Nurse and HR assistant will complete the new hire paperwork. New employees needing a physical examination will be referred to the Occupational Health Provider. The HR Director will be responsible to ensure the complete and accurate</p>	07/26/2013

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	<p>will include a health inventory and, if necessary, a physical examination to assist in suitable job placement and to serve as a basis for a health maintenance program." This policy/procedure was last reviewed/revised on 10-31-12.</p> <p>2. Review of staff # N3, N5, N7 and N9's personnel health files lacked documentation that health inventories were reviewed by facility staff.</p> <p>3. On 06-25-13 at 1410 hours, staff #48 confirmed that the new employee completes the Employment Medical Examination form, which contains medical history information, then the infection control person reviews the form and signs the form after reviewing the form. Staff #48 confirmed that there is no criteria when to refer for a physical examination.</p>		<p>completion of new hire paperwork. The new process and identification of triggers for a physical examination will be in place by July 26, 2013.</p>		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 2 services (dental and massage therapy) provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services of dental and massage therapy.</p> <p>2. In interview, on 6-26-13 at 3:45 pm, employee #A7 confirmed the above and no further documentation was provided prior to exit.</p>	S000406	<p>S 0406</p> <p>The deficiency has been corrected on 7/16/13. The Performance Improvement Program has been revised to include the following: Massage Therapy – time it takes to schedule an appointment if patient requests first available will be less than 2 days; Dental services – no patient will wait greater than 24 hours for emergency dental services. The Director of Quality and Accreditation will prevent the deficiency from recurring by monitoring the services on a monthly basis and the compliance of the PI Program.</p>	07/16/2013

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 6-24-13 at 11:30 am, in the presence of employee #A6, it was observed in a janitorial closet on the 3rd floor of the main hospital, there were 12 toilet paper rolls, 4 large handtowel rolls and 8 rolls of facial tissue stored on an open shelf. All items were not covered by any wrap and not enclosed within the shelf. This posed the potential for cross-contamination of the items used on patients, employees and visitors.</p>	S000554	<p>S 0554The deficiency will be corrected on or before 7/24/13 by covering the paper product within all janitorial closets with an approved barrier. The Environmental Services staff will report to the Manager of Environmental Services any potential situation that may pose as a potential cross-contamination. The Manager of Environmental Services will be responsible for ensuring Environmental Staff has the approved barrier in place by completing random audits with the Environmental Services staff.</p>	07/24/2013

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S000718	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(3)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(3) The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry shall be authenticated promptly in accordance with the hospital and medical staff policies.</p> <p>Based on document review and interview, the facility failed to use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries for 3 of 3 electronic signatures (MD #1, MD #2 and MD #3).</p> <p>Findings include:</p> <p>1. Review of patient #12's MR indicated that MD #1 electronically signed the Operative Report on 04-30-13.</p> <p>2. Review of patient #13's MR indicated that MD #2 electronically signed the Operative Report on 05-10-13.</p>	S000718	<p>S 0718</p> <p>The deficiency will be corrected by adding the following statement to the current confidentiality statement. "All passwords and passphrases will remain confidential to ensure the security of the medical record entries. I will not under any circumstance divulge or delegate my password, passphrase or passcode for electronic signatures to anyone at any time." All physicians will be required to read and agree to the added confidentiality and security statement by October 25, 2013. Physicians who refuse or do not comply will be reported to the Medical Executive Committee. Phase ending 8/25/2013: At the next scheduled full medical staff, August 16, 2013, all physicians will receive the updated confidentiality statement and will</p>	10/25/2013			

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	<p>3. Review of patient #14's MR indicated that MD #1 electronically signed the Operative Report on 05-07-13.</p> <p>4. On 06-26-13 at 1100 hours, staff #46 confirmed that MD #1, MD #2 and MD #3 have not signed statements to not share passcode for electronic signatures to ensure the security of the MR entries.</p>		<p>be required to acknowledge and confirm agreement with their signature. Any physician who is not in attendance will be notified of the statement update and will be required to return a signed copy.</p> <p>Phase ending 9/25/2013: The Performance Improvement Coordinator and/or the Executive Administrative Secretary will be responsible for following up with physicians who have not yet returned a signed copy of the confidentiality statement. Any physician who refuses or does not comply will be reported to the Medical Executive Committee.</p> <p>Phase ending 10/25/2013: The Performance Improvement Coordinator and/or the Executive Administrative Secretary will compile a list of physicians who have not complied with the new confidentiality statement and submit to the Medical Executive Committee.</p> <p>To ensure this deficiency does not recur in the future, all physicians who are granted privileges will be required to read and agree with the confidentiality statement. All physicians will reconfirm understanding and agreement with reappointments every two years.</p>	

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S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to ensure that patient or the responsible person gave consent for treatment for 5 of 10 emergency department medical records (MR) reviewed (Patient #1, 2, 4, 5 and 8).</p> <p>Findings include:</p> <p>1. Review of policy/procedure DCMH: Health Care Consent indicated the following: "Purpose: To provide documentation that valid consent for health care has been obtained prior to initiating health care for any individual. Standard: 1. A valid, signed, informed consent shall be present on the patient's medical record prior to the administration of health care to any individual.</p>	S000754	S 0754This deficiency was corrected on 7/1/13 through ED staff education on the correct procedure of obtaining signatures for consent of care. Patients who bypass the registration process will have consent signatures obtained by ED staff. Admitting staff will flag all required fields for completion including consent for treatment. The ED unit coordinator will ensure the deficiency from recurring by validating the signed consent. The admitting supervisor and/or ED Director will monitor ED patient charts to ensure staff obtains consent for treatment.	07/01/2013

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	<p>2. Health care is defined as: "Any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental condition. The term includes admission to a health care facility." This policy/procedure was last reviewed/revised on 01-18-13.</p> <p>2. Review of patient #1's MR indicated the patient presented to the facility emergency department on 06-23-13 and lacked documentation that the patient and or a responsible person signed the consent for treatment.</p> <p>3. Review of patient #2's MR indicated the patient presented to the facility emergency department on 06-24-13 and lacked documentation that the patient and or a responsible person signed the consent for treatment.</p> <p>4. Review of patient #4's MR indicated the patient presented to the facility emergency department on 06-24-13 and lacked documentation that the patient and or a responsible person signed the consent for treatment.</p> <p>5. Review of patient #5's MR indicated the patient presented to the facility emergency department on 05-05-13 and lacked documentation that the patient and</p>			

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NAME OF PROVIDER OR SUPPLIER  DECATUR COUNTY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 720 N LINCOLN ST GREENSBURG, IN 47240
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	<p>or a responsible person signed the consent for treatment.</p> <p>6. Review of patient #8's MR indicated the patient presented to the facility emergency department on 04-12-13 and lacked documentation that the patient and or a responsible person signed the consent for treatment.</p> <p>7. On 06-26-13 at 1005 hours, staff #43 confirmed the consents were not signed for patient #1, 2, 4, 5 and 8.</p>			

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on transfusion administration policy/procedure review, and transfusion record review the facility failed to follow approved medical staff policies/procedures for the administration of transfusions for seven of seven transfusion records reviewed.</p> <p>Findings include;</p> <p>1. On 6/25/13 review of a policy/procedure titled: "NRSG: Blood Administration Procedure, ORIGINAL DATE: 4-03-89, EFFECTIVE DATE: 08/28/2012" revealed: "PROCEDURE, F. Monitor Patient: 1. Take vital signs and record on paper lab slip a. Before starting unit of blood..."</p> <p>2. On 6/25/13 between 10:30 a.m. and 12:00 p.m. review of transfusions records #s 1 through 7 revealed there was no documentation of pre vital signs being performed.</p>	S000952	<p>S 0952 This deficiency was corrected by our hospital Laboratory Director contacting CPSI, our HIS vendor on 7/11/13 and requesting a change in the paper lab form that accompanies the unit of blood. The form previously stated vital signs at "start" of blood. The wording was changed to "pre start" in order to comply with the written procedure and nursing practice. The deficiency will be prevented from recurring by the Laboratory Blood Technician monitoring vital sign completion on lab form. The Laboratory Director will be responsible for ensuring the completion of the task.</p>	07/11/2013

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 6-24-13 at 2:00 pm in the presence of employee #A6, it was observed in the construction area near elevator 6, there was 1 fire extinguisher on the floor unsecured by chain or holder.</li> <li>On 6-24-13 at 2:50 pm in the presence of employee #A6, it was observed in the boiler room, there was 1 fire extinguisher on the floor unsecured by chain or holder.</li> <li>If any of the above extinguishers were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</li> </ol>	S001118	<p>S 1118The deficiency was corrected on 6/24/13 when our Director of Facilities spoke with the contractor responsible for the extinguishers. The contractor immediately secured the extinguishers. The deficiency will be prevented from recurring in the future by our Director of Facilities providing our "Maintenance: General Safety" policy to contractors working in our facilities. The VP of Operations and/or Director of Facilities will ensure compliance through regular and impromptu safety tours.</p>	06/26/2013

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