

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303
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S000000	The visit was for a licensure survey. Facility Number: 004811 Survey Date: 8-12-13 and 8-13-13 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 08/29/13 10/17/13 revised due to IDR	S000000		
S000318	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F) (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: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care			

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>workers, including contract and agency personnel, who provide direct patient care.</p> <p>Based on review of job descriptions, personnel/credentialing file review and interview, the facility failed to ensure CPR (cardio pulmonary resuscitation) competence for 2 of 3 PCTs (patient care techs) and for 1 of 2 LPNs (licensed practical nurses) (staff members N3 and N5 and T4).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the job descriptions for PCTs and LPNs at 10:40 AM on 8/13/13, indicated: <ol style="list-style-type: none"> the "Job description & Performance Monitoring System" for "Patient Care Technician (PCT)" "Nursing Department", indicated in the "Minimum Qualification/Requirements:" section: "...Current BLS (basic life support) Certification..." the "Job description & Performance Monitoring System" for "Staff Nurse - LPN" "Nursing Department", indicated in the "Minimum Qualification/Requirements:" section: "A current ACLS (advanced cardiac life support) and BLS Certification..." review of employee files at 10:40 AM on 8/13/13 indicated: <ol style="list-style-type: none"> staff member N3, a PCT hired 7/7/12 lacks any documentation of CPR competence (no card found at all) in the personnel file staff member N5, a LPN hired 5/1/12 had a CPR card that expired 4/13/13 and lacked documentation of current ACLS competency interview with staff member #54, the HR 	S000318	S 0318 410 IAC 15-1.4-1 Governing Board. All clinical employees that do not have current BLS will go through recert on 9/16/13. HR will use monthly tracking to schedule BLS recerts for all employees with in a 60 day window prior to expiration. This will prevent this from occuring again. Any employee that fails to complete recert will not be allowed to work until the recert is complete. Responsible party: Dianna Christman HR	09/16/2013

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S000394	<p>(human resources) director, indicated:</p> <p>a. no CPR documentation can be found for staff member N3</p> <p>b. it was unknown that the CPR for staff member N5 had expired in April</p> <p>4. The personnel file for staff T4 lacked documentation of current CPR competency.</p> <p>5. During an interview on 8-13-13 at 1510 hours, staff A2 confirmed that staff T4 lacked documentation of CPR competency.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 12 of 33 contracted services.</p> <p>Findings:</p>	S000394	S 0394 410 IAC 15-1.4-1 Governing Board. Contract service list will be updated and copies of all current contracts will be available. The list will include scope and nature of services. This list will be updated monthly and additions or deletions will be addressed in monthly QA	09/13/2013			

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S000406	<p>1. On 8-12-13 at 1530 hours, a list of all contracted services was received from staff A1. The list of contracted services failed to indicate a current provider for biomedical engineering, cardiac telemetry, cardiology/neurology testing, chemotherapy, clinical engineering, dietary and nutritional services, endoscopy, housekeeping, laundry, patient transportation, radiology services and surgical services.</p> <p>2. Review of facility documentation indicated the following services were provided under agreement: biomedical engineering by CS1, cardiac telemetry, cardiology/neurology testing, chemotherapy, clinical engineering, dietary and nutritional services, endoscopy and housekeeping services by CS2, laundry by CS3, and patient transportation, radiology services and surgical services by CS2.</p> <p>3. On 8-13-13 at 0905 hours, staff A1 confirmed the list of contracted services failed to include the indicated service providers.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p>		meetings. Contract list will be audited prior to each QA meeting. Responsible party: Rodney Midkiff CEO				

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	<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. Based on document review and interview, the facility failed to ensure that all services were evaluated and reviewed through the Quality Assessment/ Performance Improvement Program (QAPI) program for 14 services.</p> <p>Findings:</p> <p>1. The Improving Organizational Performance Plan (approved 2-13) lacked a provision for monitoring, evaluating, and reporting all services including contracted services provided at the facility.</p> <p>2. The untitled 2013 document for evaluating and reporting contracted services failed to indicate first or second quarter 2013 reporting data for the listed services of ambulance, blood bank, cardiac telemetry, cardiology/neurology testing, clinical engineering, endoscopy,</p>	S000406	S 406 410 IAC 15- 1.4-2 Quality Assessment and Improvement (Respiratory Therapy QAPI) Action: Respiratory therapy department is currently collecting quality data that is not review during the monthly QAPI committee meetings. Respiratory developed an audit tool to collect the data that will be entered in to a spread sheet for tracking and trending data. The benchmark for the performance measures is 100% documentation compliance for Decannulation Prevention Program, Documentation and Dating of equipment changes, and Initial Assessment and Evaluation. Audits tools will start 9/1/2013 by the Director of Respiratory and forwarded to the QAPI committee monthly meeting on 9/17/2013, Medical Executive committee and Hospital Board. S 406 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT Action: AMG Specialty Hospital Director of Quality will revise the Contracted	09/27/2013			

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S000420	<p>generator maintenance, health information systems, laundry, medical transcription and renal dialysis. The 2013 document lacked evidence indicating that the contracted services of chemotherapy and patient transportation were being evaluated through the QAPI program.</p> <p>3. During an interview on 8-13-13 at 1110 hours, staff A3 confirmed that the 2013 contracted services documentation lacked evidence of monitoring for the indicated services.</p> <p>4. The 2013 QAPI dashboard failed to indicate that the service of respiratory therapy was evaluated and reviewed through the QAPI program.</p> <p>5. During an interview on 8-13-13 at 1445 hours, staff A3 confirmed that the QAPI dashboard lacked indicators for evaluating the service.</p> <p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the</p>		<p>Services evaluation tool to include all services. The revised tool will insure quality services provided by all contracted services. The contracted services tool will be compared to the contracts and approved by the QAPI committee on 9/17/2013 monthly meeting, Medical Executive committee, and Hospital Board. Contracted Services will be evaluated quarterly and yearly according to the quality standards of the Contracted Services evaluation tool that the QAPI committee has approved. Responsible party: Tim Adney DQM</p>				

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	<p>following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all</p>				

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	<p>ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p>			

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	<p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure</p>				

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	<p>ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital.</p> <p>Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p>			

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S000422	<p>Based on document review and interview, the quality assessment and improvement program failed to assure that all reportable events were identified and reported to the Indiana State Department of Health (ISDH).</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Sentinel Events (approved 2-13) failed to indicate a requirement for reporting Stage III and Stage IV pressure ulcers acquired after admission to the facility as described in 410 IAC 15-1.4-2.2(a)(1). During an interview on 8-1-13 at 1245 hours, staff A1 confirmed that the policy/procedure failed to indicate the required events to be reported to ISDH. <p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's</p>	S000420	<p>S 420 410 IAC 15.1.4-2.2 Quality Assessment and Improvement Action: Central AMG Specialty Hospital will amend AMG policy # I.E.5.02 Sentinel Event policy to state the process for determining a reportable event to ISDH. The policy will state the 28 State approved Reportable Events, Process for reporting the event to ISDH. AMG will also add the 28 State approved Reportable Events to the QAPI Plan, Risk Plan. Policies will be approved in the QAPI Committee meeting on 9/17/2013, Medical Executive Committee and Hospital Board. For a long term fix new policies will be drafted and sent to AMG Corporate Office for approval and then back to appropriate committees for approval. Education of the policy will take place by staff meetings, email and during new orientation. The Director of Quality will monitor events by the use of our web based event reporting program ActionCue Clinical Intelligence. The Director of Quality will inform CEO and CCO of any reportable events. Responsible party: Tim Adney DQM</p>	09/27/2013

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	<p>quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event</p>			

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	<p>originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2)</p> <p>Based on document review and interview, the facility failed to have a policy/procedure for reporting to the</p>	S000422	S 422 410 IAC 15.1.4-2.2 Quality Assessment and Improvement Action: Central AMG Specialty Hospital will amend AMG policy #	09/27/2013			

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S000606	<p>Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedures Improving Organizational Performance (approved 2-13), Risk Management Plan (approved 2-13) and Sentinel Event (approved 2-13) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2). During an interview on 5-29-13 at 1600 hours, staff A5 confirmed that the policy/procedures failed to indicate the process for reporting an event to ISDH to ensure that events were reported in accordance with State requirements. <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes</p>		<p>I.E.5.02 Sentinel Event policy to state the process for determining a reportable event to ISDH. The policy will state the 28 State approved Reportable Events, Process for reporting the event to ISDH. AMG will also add the 28 State approved Reportable Events to the QAPI Plan, Risk Plan. Policies will be approved in the QAPI Committee meeting on 9/17/2013, Medical Executive Committee and Hospital Board. For a long term fix new policies will be drafted and sent to AMG Corporate Office for approval and then back to appropriate committees for approval. Education of the policy will take place by staff meetings, email and during new orientation. The Director of Quality will monitor events by the use of our web based event reporting program ActionCue Clinical Intelligence. The Director of Quality will inform CEO and CCO of any reportable events. Responsible party: Tim Adney</p>				

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	<p>in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on personnel file review and staff interview, the infection control committee failed to ensure the communicable disease history for 6 of 10 employees (staff members N3, N4, N5, and N8, T4 and T5)</p> <p>Findings:</p> <p>1. at 10:40 AM on 8/13/13, review of personnel health files indicated:</p> <p>a. staff member N3, a PCT (patient care tech) hired 7/7/12, lacked documentation of a history of communicable disease confirmed by a practitioner, an immune titer, or documented confirmation of having immunizations for: Rubella, Rubeola, Varicella, or Hepatitis B</p> <p>b. staff member N4, a PCT hired 3/25/13, lacked documentation of a history of communicable disease confirmed by a practitioner, an immune titer, or documented confirmation of having immunizations for: Rubella, Rubeola, Varicella, or Hepatitis B</p> <p>c. staff member N5, a LPN (licensed practical nurse) hired 5/1/12, lacked documentation of a history of communicable disease confirmed by a practitioner, an immune titer, or documented confirmation of having immunizations for: Rubella, Rubeola, Varicella, or Hepatitis B</p>	S000606	<p>S 606 Infection Control Beginning 9/1/13 all new hires will be required to provide proof of vaccines. If proof isn't available prior to first day of employment, the individual will be instructed to report to Ball Memorial Hospital Employee Health Services for drawing of titer levels and be offered the vaccine or booster. AMG will remain 100% compliant regarding ALL individuals hired after 9/1/13. HR/Dianna Christman will be the responsible party for compliance. Current AMG employee files have been audited by HR/Dianna Christman and found 23 current employees with valid documentation. Beginning 9/16/13 remaining employees will be given 15 days to provide proof. The employees who are unable to provide the documentation will then be sent to Ball Memorial Hospital Employee Health Services for the titers and offered the vaccine or booster. Based on availability, appointments will determine 100% deficiency corrected date. 60 day goal of 50% and 90 day goal of 100% compliance. Responsible party: Dianna</p>	11/15/2013

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	<p>d. staff member N8, a LPN hired 2/20/12, lacked documentation of a history of communicable disease confirmed by a practitioner, an immune titer, or documented confirmation of having immunizations for: Rubella, Rubeola, or Varicella, and lacked documentation related to any follow up for the non reactive result to the Hepatitis B titer located in the health file (any indication of whether the staff member wished to have the series, or declined the Hepatitis B series or booster, was lacking in the file)</p> <p>2. interview with staff member #54, the HR (human resources) director, at 12:55 PM on 8/13/13, indicated:</p> <p>a. this staff member is new to the HR position</p> <p>b. it was unknown by this staff member that communicable disease history was required for newly hired employees</p> <p>c. the employees listed in 1. above had completed an "Employee Health Screen" tool where some of the communicable disease history was self reported by staff at the time of hire (this was thought to be sufficient)</p> <p>d. after searching the HR department for further information, it was determined that there was no further information found, related to communicable disease history for staff members N3, N4, N5, and N8</p> <p>3. at 3:05 PM on 8/13/13, interview with staff member #50, the chief executive officer, indicated:</p> <p>a. there is no facility policy related to communicable disease history for newly hired employees</p> <p>4. The Centers for Disease Control and Prevention (CDC) publication titled Immunization of Health-Care Personnel</p>		Christman HR				

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	<p>(HCP) Recommendations of the Advisory Committee on Immunization Practices (ACIP) dated 11-25-11 indicated the following: " History of disease is no longer considered adequate presumptive evidence of measles or mumps immunity for HCP; laboratory confirmation of disease was added as acceptable presumptive evidence of immunity. History of disease has never been considered adequate evidence of immunity for rubella ...[and] ...Criteria for evidence of immunity to varicella were established. For HCP they include written documentation with 2 doses of vaccine, laboratory evidence of immunity or laboratory confirmation of disease, diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider. "</p> <p>5. On 8-13-13 at 1400 hours, staff A2 was requested to provide a policy/procedure for determining the communicable disease status of all personnel and none was provided prior to exit.</p> <p>6. During an interview on 8-13-13 at 1500 hours, staff A2 confirmed that no policy/procedure was available.</p> <p>7. Personnel health records for staff T4</p>						

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S000744	<p>and T5 lacked documentation of vaccination records, health care provider-diagnosed rubella, rubeola and varicella or laboratory evidence of immunity (or confirmation of varicella disease).</p> <p>8. During an interview on 8-13-13 at 1510 hours, staff A2 confirmed that the personnel files lacked the indicated documentation.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure the completion of medical records related to the nursing initial assessment form for 3 of 5 closed medical records reviewed, (pts. #3, #6, and #7), and related to dating of the nutrition assessment for one patient (pt. #2).</p> <p>Findings: 1. at 11:40 AM on 8/12/13, review of the policy manual indicated a policy titled "Initial Interdisciplinary Assessment",</p>	S000744	S 744 410 15-1.5-4 Medical Record Services Action Plan: 1-2. "Initial Interdisciplinary Assessment and "Initial Nursing Assessment " Nursing Policy 11.1.9.05 and Policy 11.1.00 will be reviewed during the September staff meeting. The initial nursing document along with the daily nursing form will be presented with each section discussed. Daily documentation requirements will be reviewed along with expectations from each staff member. Non-compliance of documentation requirements will	09/27/2013

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	<p>Policy Number: II.I.9.05, with an effective date of 9/4/12, indicated:</p> <p>a. under section "I. Policy", it reads: "Each patient's physical, psychological, emotional, pain, cultural, and social status are assessed upon admission by nursing and each discipline triggered by the nursing assessment. The documentation is per the Nursing Initial Assessment Form and the Therapy Evaluation Form."</p> <p>b. under section "II. Procedure", it reads: "...A. Nursing Documentation :</p> <p>1. A registered nurse is responsible for completing the initial patient physical assessment...2. Initial nursing assessment is initiated within 2 hours of admission and completed within 24 hours...."</p> <p>2. at 2:30 PM on 8/13/13, review of closed patient medical records indicated:</p> <p>a. pt. #3 had an "Initial Nursing Assessment" dated 6/14/13 that lacked completion in the sections: "Patient Valuables"; "Orientation", "Psychosocial"; "Social Behaviors"; "Vital Signs"; "Nutrition"; "Assessment of Readiness to Learn"; "Discharge Planning/Identified Needs"; and "Significant Problems/Barriers to Discharge Identified"</p> <p>b. pt. #6 had an "Initial Nursing Assessment" dated 5/8/13 that lacked</p>		<p>result in disciplinary action. Education will also be included with all new staff during orientation. Weekly audits will be reviewed by CCO. 3. "Nutrition Assessment" Review of documentation requirements will be provided to all contracted employees. Random audits during time of employment will be reviewed by CCO. Responsible party: Tina Riegle CCO</p>	

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	<p>completion in the sections: "Vital Signs"; "Pain History"; "Fall Risk Assessment"; "Discharge Planning/Identified Needs"; and "Significant Problems/Barriers to Discharge Identified"</p> <p>c. pt. #7 had an "Initial Nursing Assessment" dated 4/20/13 that lacked completion in the sections: "Social Behaviors"; "Psychosocial"; "Discharge Planning/Identified Needs"; and "Significant Problems/Barriers to Discharge Identified"</p> <p>3. While on tour of the nursing unit at 1:30 PM on 8/12/13, the medical record for pt. #2 was reviewed and it was observed that the "Nutrition Assessment" documented by the dietician was not dated making it impossible to determine if the assessment occurred within the expected time frame for the patient admitted on 8/8/12</p> <p>4. interview with staff member #52, the chief clinical officer (nursing executive), at 12:00 PM on 8/12/13, 11:45 AM and 2:15 PM on 8/13/13, indicated:</p> <p>a. as listed in #1 above, documentation is lacking, as required, for sections of the initial nursing assessment forms for pts. #3, #6 and #7</p> <p>b. the dietitian should have dated</p>				

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S000912	<p>their nutrition assessment document for pt. #2</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review,</p>	S000912	S 912 410 IAC 15-1.5-6 NURSING SERVICE I.-3 Lack of	09/27/2013
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	<p>patient medical record review, and staff interview, the nursing executive failed to ensure the implementation of facility policies related to: attendance at IDT (interdisciplinary team) meetings; weekly meetings of the IDT; and nursing VS (vital signs) documentation for patients receiving blood products.</p> <p>Findings:</p> <p>1. at 1:15 PM on 8/13/13, review of the policy and procedure "Interdisciplinary Care Plans", policy number IV.S.19.03, with an effective date of 9/18/12, indicated:</p> <p>a. under section "I. Policy", it reads: "Respiratory care shall meet at least weekly with the attending physician, nursing, and other involved and/or interested parties, to discuss and plan goals and achievements for each patient."</p> <p>b. under section "II. Procedure:", it reads: "...Patient care team conferences will be held for each patient at least weekly..."</p> <p>2. at 2:30 PM on 8/12/13 and 9:00 AM on 8/13/13, review of patient medical records indicated:</p> <p>a. pt. #3:</p> <p>A. was admitted on 6/14/13 (Friday) and had an IDT meeting on 6/19/13 prior to discharge on 6/22/13</p> <p>B. lacked attendance by the physician</p>		<p>documentation with Interdisciplinary Care Plans: Action Plan: Nursing personnel, physician, and all ancillary staff will be provided current policies regarding Interdisciplinary care plans and documentation requirements. Education will be provided in September 2013. Disciplinary action will result with non-compliance of appropriate documentation. Evaluation of effectiveness will be demonstrated by review of signatures of all ancillary staff on care plan. Random audit of 5 charts will be completed weekly. Case management will be responsible for these reviews. Responsible party: Michelle Brogdon CSM 4. "Blood Administration" Action Plan: Nursing personnel will be educated regarding blood administration policy 11.K.00. Focus of education will be on reflecting changes with frequency of monitoring of vital signs according to AMG policy. Education will be provided annually, and with all new-hires. Evaluation of effectiveness with be determined with a weekly random audit of 5 charts. The CCO will be responsible for reviewing the audit data. Responsible party: Tina Riegle CCO</p>				

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	<p>at the IDT meeting on 6/19/13</p> <p>C. lacked nursing attendance and documentation other than that by the wound nurse at the 6/19/13 IDT meeting</p> <p>b. pt. #4:</p> <p>A. was admitted on 6/13/13 (Thursday) and discharged on Tuesday, 7/2/13</p> <p>B. had only one IDT meeting note on 6/19/13 and lacked documentation of a meeting for the week of 6/23/13 to 6/29/13</p> <p>C. lacked attendance by the physician at the IDT meeting on 6/19/13</p> <p>D. lacked nursing attendance and documentation other than attendance by the wound nurse with wound notes being "n/a" (not applicable) at the IDT meeting on 6/19/13</p> <p>c. pt. #5:</p> <p>A. was admitted on Tuesday, 6/18/13 and discharged on Monday, 7/8/13</p> <p>B. lacked documentation of an IDT meeting for the week of 6/23/13 to 6/29/13</p> <p>d. pt. #6:</p> <p>A. was admitted on Wednesday, 5/8/13 and discharged Saturday, 6/8/13</p> <p>B. had IDT meetings documented on 5/28/13 and 6/5/13</p> <p>C. lacked attendance by the</p>			

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	<p>physician at the IDT meetings on 5/28/13 and 6/5/13</p> <p>D. lacked having documentation of an IDT meeting for the week of 5/19/13 to 5/25/13</p> <p>E. lacked nursing attendance and documentation, other than that by the wound nurse, at the 5/28/13 and 6/5/13 meetings</p> <p>e. pt. #7:</p> <p>A. was admitted on Saturday, 4/20/13 and discharged on Saturday, 5/25/13</p> <p>B. lacked documentation of any IDT meetings during their 30+ days of hospitalization</p> <p>3. interview with staff member #55, the RN (registered nurse) case manager, at 1:10 PM on 8/13/13, indicated:</p> <p>a. the physician usually attends when patient family members are present, but has not signed his/her attendance on the IDT notes form</p> <p>b. it was unknown by this staff member that the IDT notes form needed to be completed with each weekly meeting, it was thought they only needed to be completed when families attended</p> <p>c. it cannot be determined that weekly IDT meetings occurred without the form being completed with each discipline signing in attendance</p>						

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	<p>4. at 9:50 AM on 8/13/13, review of the policy and procedure "Blood Administration", policy number II.K.11.00, with a revision date of 10/2/12 indicated:</p> <p>a. in the section "II. Procedure", it reads: "...21. Monitor vital signs at 5 minutes, then every 15 minutes for the first hour, then every 30 minutes until unit is infused. Document a final set of vital signs following completion of the transfusion..."</p> <p>5. at 2:30 PM on 8/12/13 and 9:00 AM on 8/13/13, review of patient medical records indicated:</p> <p>a. pt. #7:</p> <p>A. received a blood transfusion on 5/14/13</p> <p>B. had a start time of the transfusion at 0610 hours and a stop time of 0930 hours</p> <p>C. vital signs were documented as follows: "Pre transfusion"; "at 15 Minutes"; and "Post transfusion"</p> <p>6. interview with staff member # 52, the chief clinical officer, at 9:50 AM on 8/13/13 indicated:</p> <p>a. the blood administration policy is a "corporate" policy</p> <p>b. the blood administration form that nursing staff utilize is from the host hospital (which the blood products are</p>			

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NAME OF PROVIDER OR SUPPLIER CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303		
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S000932	<p>obtained from and a form that is required by that facility)</p> <p>c. currently, nursing staff is not monitoring vital signs per the blood administration policy</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the nurse executive failed to ensure the implementation of the facility policy related to the completion of nursing care plans for 3 of 7 records reviewed. (pts. #2, #6, and #7)</p> <p>Findings:</p> <p>1. at 1:15 PM on 8/13/13, review of the policy and procedure "Plan of Care", policy number II.I.9.02, with an effective date of 8/21/12, indicated:</p> <p>a. on page one under section "I. Policy", it reads: "...A. Assessment: 1. After a thorough nursing assessment is done, care plans are completed by an RN (registered nurse)..."</p> <p>b. on page two under section "I. Policy", it reads: "...B...3. A written plan of care is initiated for each patient within 24 hours of admission..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #2 (open medical record) was admitted on</p>	S000932	S 932 410 1AC 15-1.5-6 Nursing Service 1-4. "Plan of Care" Action Plan: Nursing personnel will be re-educated regarding policy 11.1.9.02, Plan of Care. Documentation form will be reviewed to ensure accurate documentation responsibilities. Staff will be informed of non-compliance with documentation will result in disciplinary action. Care plans will be individualized according to specific needs. The care plan will be completed by an RN and implemented within 24 hours of admission. Care plans will be updated with any change in patient condition, and weekly at time of team conference. To ensure the deficiency is corrected, 5 random charts will be audited weekly. The CCO will	09/27/2013	

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S001168	<p>8/8/13 and lacked completion of a nursing care plan (document in the chart was blank)</p> <p>b. pts. #6 and #7 had no nursing care plan in their medical records</p> <p>3. interview with staff member #52, the chief clinical officer, at 1:30 PM on 8/12/13, indicated the nursing care plan for patient #2 was blank</p> <p>4. interview with staff member #53, the medical records director, at 10:35 AM on 8/13/13, indicated no nursing care plans can be found for pts. #6 or #7</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations.</p> <p>Findings:</p> <p>1. The facility Zoll M Series Operator 's Guide (2010 edition) Section 10 General Maintenance indicated the Operators Shift Checklist for M Series Products regarding the manufacturer's</p>	S001168	<p>be responsible for reviewing audits and providing documentation of non-compliance. Responsible party: Tina Riegler</p> <p>S1168 IAC 15-1.5-8 Physical Plant (Crash Cart) Action: The Zoll Defibrillator will be discharged in accordance with manufactures recommendations. The manufactures guidelines are laminated and attached to the crash cart for employees to review and follow. The Crash Cart policy II.K.11.46 will be revised with amendment to the policy stating the correct discharge process and approved in the QAPI meeting on 9/17/2013. For a long term fix the policy will be revised and sent to AMG</p>	09/20/2013			

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	<p>recommendations for daily inspection and testing of the defibrillator and indicated the energy setting for testing the defibrillator was 30 Joules.</p> <p>2. The policy/procedure Crash Cart (approved 2-13) failed to indicate a provision for discharging the Zoll M-Series defibrillator per the manufacturer ' s recommendations and failed to indicate the discharge process described in the Operators Shift Checklist. The policy/procedure indicated the energy setting for testing the defibrillator was 200 Joules.</p> <p>3. During a tour of the nursing unit on 8-12-13 at 1200 hours, a Zoll M Series defibrillator was observed on a cart opposite the nursing station. The Crash Cart Checklist located on top of the Code Cart failed to indicate the discharge process described in the Operators Shift Checklist or indicate that the additional checks listed on the operators shift checklist were completed with acceptable results per the manufacturer ' s recommendations.</p> <p>4. During an interview on 8-12-13 at 1220 hours, staff A2 confirmed that the policy/procedure and crash cart checklist failed to ensure that the equipment was checked in accordance with the</p>		<p>Corporate office for approval. The Crash Cart policy II.K.11.46 will be approved by QAPI committee, Medical Executive committee, and Hospital Board. The manufactures defibrillator discharge recommendations was laminated and placed on the crash cart on 8/13/2013 Responsible party: Tina Riegle CCO</p>		

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S001316	<p>manufacturer's recommendations.</p> <p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(2)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(2) is initiated in a timely manner within time frames as established by written hospital policy; Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of the policy related to initial assessment by social services for 6 of 7 records reviewed. (pts. #1, #2, #3, #4, #6, and #7)</p> <p>Findings: 1. at 3:25 PM on 8/12/13, review of the policy and procedure "Assessment and Reassessment", policy number II.I.9.00, with an effective date of 8/21/12, indicated: a. under the section "II. Procedure", it reads in item "C. Social Services:". "The Case Manager/Social Worker shall complete an initial evaluation including psychosocial assessment within 72 hours of admission..."</p> <p>2. Review of patient medical records indicated: a. pt. #1 was admitted on 8/2/13 with the first case manager notes dated 8/8/13 b. pt. #2 was admitted 8/8/13 and lacked any case management notes or assessment as of 8/13/13</p>	S001316	S1316 410 IAC 15-1.5-10 Utilization review and discharge planning. The Director of Case Management will be responsible for insuring that the initial case management assessment of each new patient will occur within 72 hours of admission per policy. The assessment can be completed by the RN case manager or social worker. Documentation must be present to indicate that attempts to contact family to complete the assessment have been made if family is unreachable during this time frame. Monthly audits will be performed on all new admissions for each month to insure compliance for a period of 3 months. Responsible party: Michelle Brogdon DCSCM	09/13/2013			

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S001318	<p>c. pt. #3 was admitted on 6/14/13 and had the first case manager notes dated 6/20/13</p> <p>d. pt. #4 was admitted on 6/13/13 and had the first case management notes on 6/17/13</p> <p>e. pt. #7 was admitted 4/20/13 and discharged on 5/25/13 and lacked any documentation in the medical record by case management</p> <p>3. interview with staff member #55, the RN (registered nurse) case manager, at 1:10 PM on 8/13/13, indicated:</p> <p>a. this staff member was hired in the position of case manager in May 2013</p> <p>b. the previous case manager was still at the facility at the time of hire so that there was no gap in case management coverage</p> <p>c. this staff member has not yet met pt. #2 who was admitted on 8/8/13</p> <p>d. it was unknown by this staff member that the facility policy required an assessment and initiation of the case management documentation within 72 hours of admission</p> <p>4. interview with staff member #53, the medical records director, at 10:35 AM on 8/13/13, indicated there were no case management notes for pt. #7 that could be found</p> <p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C) (D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p>						

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	<p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following:</p> <p>(A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that transfer forms were completed for 2 of 2 patients transferred: (pts. # 3 and #7)</p> <p>1. at 1:15 PM on 8/13/13, review of the policy and procedure "Emergency Transfers", Policy Number II.K.11.02, with an effective date of 8/21/12, indicated:</p> <p>a. under section "II. Procedure:", it reads: "...11. Complete the Hospital Transfer Form..."</p> <p>2. review of patient medical records indicated 2 of 2 transfer patients lacked a copy of the transfer form which would indicate copies of the medical record that were completed for transfer, and which appropriate medical record copies were sent with the patient, as follows:</p> <p>a. pt. #3 was transferred to another acute care facility on 6/22/13 and lacked a transfer form b. pt. #7 was transferred to another acute care facility on 5/25/13 and lacked a transfer form</p> <p>3. interview with staff member #53, the medical records director, at 10:35 AM and 2:55 PM on 8/13/13, indicated:</p>	S001318	S1318 410 IAC 15-1.5-10 Utilization Review and Discharge Planning Nursing staff will be educated on the use of the "Emergency Transfer" forms in the Septemebr staff metings. Monitoring through weekly audits will be completed to ensure compliance. Responsible party: Tina Riegle CCO	09/27/2013			

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	<ul style="list-style-type: none"> a. no transfer forms could be found for patients #3 and #7 b. the receiving facilities were contacted to see if the original was sent with the patient (and no copy kept here), and no transfer forms could be found at the receiving facilities c. facility policy related to patient transfers was not implemented as required 				