

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151329	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2016
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NAME OF PROVIDER OR SUPPLIER MARGARET MARY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 321 MITCHELL AVE BATESVILLE, IN 47006
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S 0000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004718</p> <p>Survey Date: 04-11/13-2016</p> <p>QA: cjl 05/24/16</p> <p>IDR Committe Held on 07-27-16. Tag S01186 modified. JL</p>	S 0000		
S 0270 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality activities for 1 directly-provided services and 1 other activity for calendar year 2015.</p>	S 0270	1. The Hospital Performance Improvement Plan was revised to include monitoring and reporting for Outpatient Psychiatry (Behavioral Health). This monitor will be reported through the	06/02/2016

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>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the directly-provided service of outpatient psychiatry and the activity of reportable events. 2. Interview, of employee #A1, Quality Services Director, on 04-12-2016 at 12:25 pm, confirmed all the above and no further documentation was provided prior to exit. 		<p>established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached. The Annual Patient Safety Summary Report was revised to include activity of reportable events. The Annual Patient Safety Summary Report will be reported through the established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached. 2. A cross reference of the QAPI Monitor List provided by the Indiana State Department of Health Surveyors at the time of survey to the Organization PI Plan was conducted to assure all applicable services, including Outpatient Psychiatry (Behavioral Health), is part of the hospital's QAPI program. Supporting documentation is attached. The Performance Improvement Organizational Reporting & Communication (Appendix A) of Performance Improvement Plan was revised to include Reportable Events. Supporting documentation is attached. 3. Margaret Mary Health's Department Managers were reminded that any new services, including contracted services, are part of the hospital's QAPI program. A template was developed for the Annual Patient Safety Summary Report to assure annual reporting of activity of reportable events. Supporting</p>		

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S 0406 Bldg. 00	<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. Based on document review and interview, the facility failed to include</p>	S 0406	<p>documentation is attached.</p> <p>4. The Licensed Clinical Social Worker for Outpatient Psychiatry (Behavioral Health) will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and the Quality Services Director will be responsible for submitting data to Medical Staff and Board of Directors. Supporting documentation is attached. The Quality Services Director will be responsible for ongoing annual submission of the Annual Patient Safety Summary, including activity of reportable events, to the Medical Staff and Board of Directors. Supporting documentation is attached.</p> <p>1. The Hospital Performance Improvement Plan was revised to</p>	06/02/2016	

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S 0952	standards for 1 directly-provided service, as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2015. Findings include: 1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include standards for the directly-provided service of outpatient psychiatry. 2. In interview, employee #A1, Quality Services Director, on 04-12-2016 at 12:15 pm, confirmed the above and no further documentation was provided prior to exit. 410 IAC 15-1.5-6 NURSING SERVICE		include monitoring and reporting for Outpatient Psychiatry (Behavioral Health). This monitor will be reported through the established hospital wide system to include Medical Staff and Board of Directors. Supporting documentation is attached. 2. A cross reference of the QAPI Monitor List provided by the Indiana State Department of Health Surveyors at the time of survey to the Organization PI Plan was conducted to assure all applicable services, including Outpatient Psychiatry (Behavioral Health), is part of the hospital's QAPI program. Supporting documentation is attached. 3. Margaret Mary Health's Department Managers were reminded that any new services, including contracted services, are part of the hospital's QAPI program. Supporting documentation is attached. 4. The Licensed Clinical Social Worker for Outpatient Psychiatry (Behavioral Health) will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and the Quality Services Director will be responsible for submitting data to Medical Staff and Board of Directors. Supporting documentation is attached.		

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Bldg. 00	<p>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 document review, the facility failed to follow the approved medical staff policy and procedure for 2 of 6 transfusions selected for review.</p> <p>Findings included:</p> <p>1. Review of policy/procedure titled "Patient Care-Medication Blood Transfusion" supplied to the surveyor by SP#4 upon request for nursing's transfusion administration policy/procedure revealed:</p> <p>a. page 5 : "5. Appropriate intervals for vital signs include pre-transfusion time and date as noted on the component." signs (within 30 minutes from start of blood), 15 minutes from start of blood, 1 hour after initiating blood and on completion."</p> <p>b. page 5 : "7. All blood/blood components must be transfused within 4 hours of issuance from the Blood Bank and before the blood product expiration</p>	S 0952	<p>1. The Blood Transfusion policy was reviewed with Medical-Surgical and Special Care RNs at the May Department Staff meeting. Supporting documentation is attached. 2. A review of all patients receiving blood transfusions is being conducted to assure appropriate intervals for vital signs and blood components are transfused within 4 hours of issuance from the blood bank. Supporting documentation is attached. 3. The Medical-Surgical and Special Care RNs were reminded to include appropriate intervals for vital signs and blood components are transfused within 4 hours of issuance from the blood bank. In addition, Medical-Surgical and Special Care RNs were given a mandatory Blood Inservice, including a post test that reviewed appropriate intervals for vital signs and blood components are transfused within 4 hours of issuance from the blood bank in May 2016. Orientation of new Medical-Surgical and Special</p>	05/31/2016			

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S 1118 Bldg. 00	<p>time and date as noted on the component."</p> <p>2. Review of transfusion records revealed:</p> <p>a. Transfusion on P#1 (P=Patient) had no documented 1 hour vitals.</p> <p>b. Transfusion on P#6 left refrigeration at 1344 hrs but was not completed until 1800 which is greater than 4 hours.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and document review, the facility created conditions which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings include:</p> <p>1. On 04-11-2016 at 2:35 pm in the presence of employees #A5 and #A6, it was observed in the storage shed outside</p>			S 1118	<p>Care RNs will include a thorough review of the Blood Transfusion policy. Supporting documentation is attached. 4. The Medical-Surgical and Special Care Manager will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and submitted to the hospital's Quality Improvement Director. Supporting documentation is attached.</p> <p>1. All of the compressed gas cylinders in the outside storage shed by the physical plant were secured properly. 2. A review of all the compressed gas cylinders at Margaret Mary Health campuses were checked to see if properly stored and secured. 3. A memo was sent to the AirGas (vendor that provides compressed gas cylinders to Margaret Mary Health) and</p>		06/03/2016

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S 1164 Bldg. 00	<p>the physical plant area there were 2 small medical air compressed gas cylinders standing upright on the floor unsecured by chain or holder.</p> <p>2. Review of a facility policy entitled <i>Compressed Gas Cylinders</i>, approved 03-21-2014, indicated "... cylinders should be properly secured by chain in storage areas ... so as to offer some protection against falling or being pushed over."</p> <p>3. If any of the above cylinders were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM)</p>	S 1164	<p>Margaret Mary Materials Management Department Team Members were reminded that all compressed gas cylinders need to properly stored and secured. Supporting documentation is attached. 4. The Materials Management Manager will be responsible for the ongoing monthly tracking of data utilizing the hospital's Performance Improvement (PI) for Departments (PDSA) form and submitted to the hospital's Quality Improvement Director. Supporting documentation is attached.</p> <p>1. A Preventative Maintenance was completed on the Dietary Dishwasher and Renal Dialysis Machines. Supporting</p>	06/06/2016	

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S 1166 Bldg. 00	<p>for 2 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 04-11-2016 at 11:00 am, employee #A5, Safety & Security Coordinator, was requested to provide documentation of PM on a dietary dishwasher and renal dialysis machine. Review of a document entitled MAINTENANCE located on page 25 of the Hobart Dish Machine handbook, indicated the manufacturer indicated steps to follow for periodic maintenance. Interview of employee #A5 on 04-12-13 at 2:55 pm, indicated there was no documentation of PM on the above-stated equipment and none was provided prior to exit. <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be</p>		documentation is attached. 2. A review of the Equipment Inventory List conducted by the Director of Facilities was completed to assure the same deficiency practice does not occur. 3. The Dietary Dishwasher and Renal Dialysis Machines were added to the Preventative Maintenance Schedule by the Director of Facilities. Supporting documentation is attached. 4. The Director of Facilities will be responsible for the ongoing semi-annual tracking of the Preventative Maintenance Schedules for Dietary Dishwasher and Renal Dialysis Machines.		

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	<p>kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the facility failed to document current electrical leakage check for 10 of 23 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 04-11-2016 at 11:00 am, employee #A5, Safety & Security Coordinator, was requested to provide documentation of current electrical leakage checks for 23 pieces of equipment. Review of facility documents indicated there was no documentation for an audiometer, computer tomography scanner, dietary dishwasher, emergency code call system, floor scrubber, gamma camera, linear accelerator, mammogram scanner, renal dialysis machine and ultrasound machine. Interview of employee #A5, on 04-12-2016 at 2:55 pm, confirmed there was no above-requested documentation. No other documentation was provided prior to exit. 	S 1166	<ol style="list-style-type: none"> Electrical leakage current values are not applicable to the following devices because they are either battery operated, hardwired, or dc transformer: audiometer, computer tomography scanner, dietary dishwasher, emergency code call system, floor scrubber, gamma camera, linear accelerator and mammogram scanner. A electrical leakage check was performed on renal dialysis machines, and the ultrasound machines. Supporting documentation attached. TriMedx (Biomedical Engineering Contractor) will ensure electrical leakage current values are documented in preventative maintenance notes for all applicable equipment. When electrical leakage current is not applicable to the device, i.e., the device is battery operation, hard wired, or a dc transformer, TriMedx will document the leakage current is not applicable. Supporting documentation is attached. TriMedx (Biomedical Engineering Contractor) will ensure electrical leakage current values are documented in preventative maintenance notes for all applicable equipment. The Director of Facilities will be responsible to ensure the documentation by TriMedx of the 	06/06/2016

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S 1186 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to include in its fire control plan, a provision to cooperate with firefighting authorities in 1 instance.</p> <p>Findings include:</p>	S 1186	<p>ongoing triennial electrical leakage current values are documented in the preventative maintenance notes for all applicable equipment.</p> <p>The Fire Safety Management Plan and the Code Red: Fire Response Plan were revised to include a provision to "Cooperate" with firefighting authorities. Supporting documentation is attached. A partial IDR is being requested for S-1186 due to the following facilities being inadvertently listed on the</p>	06/03/2016

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	<p>1. Review of a facility policy entitled Fire Safety Management Plan, approved 7/14, indicated it did not include a provision to cooperate with firefighting authorities.</p> <p>2. Interview of employee #A6, Safety & Security Coordinator, on 04-12-2016 at 1:10 pm, confirmed the above and no other documentation was provided prior to exit.</p>		<p>document titled "List of Eligible Sites for Survey": OS#2 - Outpatient Rehabilitation Center OS#3 - Occupational Health & Wellness Clinic OS#4 - Margaret Mary Physician Partners</p> <p>The above sites are designated as "Business Occupancy" and the appropriate number of fire drills per NFPA Life Safety Code and hospital policy were conducted as appropriate for "Business Occupancy". The fire drills that were conducted were documented and provided at the time of survey.</p>	