



**Oklahoma State University Medical Trust
Regular Rescheduled Meeting of the Board of Trustees**

**OSU Medical Center
Administrative Board Room | 2nd Floor
744 West 9th Street, Tulsa, Oklahoma 74127**

Tuesday, January 7, 2020 | 1:45 PM

MEETING AGENDA

I.	Call to order and establishment of a quorum	Ed Keller, Chairman	1:45 PM
II. ACTION	Discussion, consideration and possible vote to approve the minutes from the October 30, 2019 meeting, and any amendments made thereto by Trustees – (ATTACHMENT 1)	Ed Keller, Chairman	1:47 PM
III.	FINANCE COMMITTEE – (ATTACHMENT 2) (a) Review of MTD and YTD November 2019 Financials	Ed Keller, Chairman	1:50 PM
IV. ACTION ACTION ACTION ACTION	JOINT CONFERENCE COMMITTEE – (ATTACHMENT 3) (a) Discussion, consideration and possible vote to approve the Organized Medical Staff Appointments and Credentials (Initial and Renewal) (b) Discussion, consideration and possible vote to approve the following Policy: Emergency Operation Plan (EOP) (c) Discussion, consideration and possible vote to approve the New, Changed and Retired Performance Improvement Measures for the Emergency Department (d) Discussion, consideration and possible vote to approve the following Department Chairman and Vice Chairman elections: Internal Medicine – Kathy Cook, DO, Chairman and Steve Kim, DO, Vice Chairman; Pediatrics – Heather Rector, DO, Chairman and Amanda Foster, DO, Vice Chairman; and Surgery – Michael Thomas, MD, Chairman and Brian Diener, DO, Vice Chairman (e) Healthcare Facilities Accreditation Program (“HFAP”) 2019 Survey Progress Report, attached and available for review (f) Committee Minutes Available for Review from the following committees to the Trust: Pharmacy and Therapeutics Committee, Quality Council, Utilization Review Committee, Transfusion Review Committee, Safety Committee and Dashboard, Infection Control Committee and Patient Experience Committee	Kayse Shrum, DO Trustee and President, OSU Center for Health Sciences	2:00 PM

V.	OKLAHOMA STATE UNIVERSITY MEDICAL CENTER STRATEGIC INITIATIVE REPORTS AND ADMINISTRATOR UPDATE		
	(a) ACGME Transition Team	Brenda Davidson	2:15 PM
	(b) Clinical & Service Quality Improvement Team	Matt Adams	2:17 PM
	(c) Network Cohesion Team	Ty Griffith	2:19 PM
	(d) Vacated Space Team	Matt Adams	2:21 PM
	(e) FQHC Team	Matt Adams	2:23 PM
	(f) Service Portfolio Team	Matt Adams	2:25 PM
	(g) Administrator Update	Matt Adams	2:27 PM
VI.	UNFINISHED BUSINESS	Ed Keller, Chairman	2:32 PM
VII.	NEW BUSINESS (Limited to Matters Not Known About and Which Could Not Have Been Reasonably Foreseen Prior to Posting of the Agenda)	Ed Keller, Chairman	2:34 PM
VIII.	ANNOUNCEMENTS (if any)	Ed Keller, Chairman	2:36 PM
	(a) Next regularly-scheduled Trust meeting: February 20, 2020 at OSU Center for Health Sciences, 1111 West 17 th Street, Tulsa. The 2020 meeting time has changed and meetings will begin at 1:30 PM.		
IX.	EXECUTIVE SESSION	Ed Keller, Chairman	2:37 PM
ACTION	(a) Discussion, consideration and possible vote to authorize and convene an Executive Session, as authorized by Title 25, Oklahoma Statutes, Section 307(B)(4), for the purpose of reporting confidential communications of the Hospital's Risk Management Reports (September-October, 2019) to the Trust and Trust Counsel, and as authorized by Title 25, Oklahoma Statutes, Section 307(B)(7)	(Report by Matt Adams, Administrator)	
ACTION	(b) Discussion, consideration and possible vote to adjourn the Executive Session and reconvene to the Regular Trust Meeting	Ed Keller, Chairman	2:44 PM
X.	ADJOURNMENT	Ed Keller, Chairman	2:45 PM
ACTION	Motion and Vote to Recess or Adjourn		

**OKLAHOMA STATE UNIVERSITY MEDICAL TRUST
REGULAR MEETING OF TRUSTEES**

**OSU Center for Health Sciences
Barson Building | 4th Floor
1111 West 17th Street, Tulsa, Oklahoma 74107**

Wednesday, October 30, 2019 | 1:45 PM

MINUTES

A Regular Meeting of the Oklahoma State University Medical Trust (“Trust”) was convened in the Barson Building, 4th Floor, at the OSU Center for Health Sciences campus, 1111 West 17th Street, Tulsa, Oklahoma, on Wednesday, October 30, 2019, at 1:45 PM. The notice and agenda for the meeting were posted at the Trust’s main office prior to 1:45 PM on October 29, 2019, in compliance with the Oklahoma Open Meeting Act. Items contained in the meeting booklet provided to the Trustees are incorporated by reference in these Minutes, and the contents of the meeting booklet are included in the Minute Book.

TRUSTEES PRESENT: Ed Keller, Jay Helm (arrived at 2:24pm), Barry Steichen, Doug Evans and Kevin Corbett

TRUSTEES ABSENT: Kayse Shrum, DO

GUESTS: Matt Adams, Eric Polak, Noe Gutierrez Jr, Kevin Gore, CPA, Dennis Blankenship, DO, Rhonda Hanan, RN, Ty Griffith, Brenda Davidson, and Glenn Coffee, Esq.

I. Call to order and establishment of a quorum - Ed Keller, Chairman

The meeting was called to order by Chairman Keller at 2:14 PM.

II. Introduction/Seating of New Trustee Kevin Corbett - Ed Keller, Chairman

Chairman Keller introduced Mr. Evans as a newly-seated Trustee to the Oklahoma State University Medical Trust Board of Trustees and expressed gratitude on behalf of the Trustees for his willingness to serve on the Trust Board.

III. Discussion, consideration and possible vote to approve the minutes from the June 27, 2019 meeting and the August 22, 2019 meeting, and any amendments made thereto by Trustees - Ed Keller, Chairman (ATTACHMENT 1)

Mr. Steichen moved to approve the minutes from the June 27, 2019 and the August 22, 2019 meetings. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Steichen, Evans and Corbett

NAY: None

IV. Finance Committee – Ed Keller, Chairman (ATTACHMENT 2)

(a) 2019 Oklahoma State University Medical Authority Financial Audit Presentation - Kevin Gore, CPA, BKD, LLP

Mr. Gutierrez Jr introduced Kevin Gore, CPA, and at Mr. Gutierrez Jr’s request, Mr. Gore provided a report on the 2019 Oklahoma State University Medical Authority Financial Audit. Mr. Gore reported that there were no adjustments and reported a clean opinion.

(b) Review of MTD and YTD September 2019 Financials

Mr. Gutierrez Jr reviewed the month-to-date and year-to-date September 2019 Financials and his report was as follows: for the month of September, OSUMC reported a net loss in the amount of \$391K, or a -4.0 percent margin, which compares unfavorably to the budgeted operating margin of 1.9 percent for the month. This net loss was primarily due to a reduction in volumes compared to budget and prior year. Looking at the major volume indicators for the three months ending September 2019, admissions were down compared to last fiscal year by 3.9 percent or 49 admits. Observation or short stay patients were up over the previous year by 9 visits, or 0.9 percent. When observations and admissions are combined, total patients admitted to the Facility decreased compared to the previous year by 1.8 percent, or 40 encounters. Compared to the September 2019 YTD budget, admissions and observations were down 11.0 percent or 274 encounters. Outpatient visits decreased compared to prior year by 231 visits, or 4.0 percent, however, emergency room visits were up by 225 visits, or 2.2 percent. For the three months ending September 2019, OSUMC reported a net loss of \$909,000, or a -3.1 percent margin, which was below the budgeted operating margin of 1.7 percent. For the three months ending September 2019, OSUMC’s days cash on hand were 122. A lengthy discussion ensued.

V. Governance Committee – Ed Keller, Chairman (ATTACHMENT 3)

(a) Discussion, consideration and possible vote to approve the following recommended slate of nominees as the officers of the Oklahoma State University Medical Trust (the “Trust”) for Fiscal Year 2020: Ed Keller, Chairman; Jay Helm, Vice Chairman; Jay Helm, Secretary; and Doug Evans, Treasurer

Mr. Steichen moved to approve the officers of the Oklahoma State University Medical Trust (the “Trust”) for Fiscal Year 2020: Ed Keller, Chairman; Jay Helm, Vice Chairman; Jay Helm, Secretary; and Doug Evans, Treasurer. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

- (b) Discussion, consideration and possible vote on setting the regular Trust Meeting Dates for 2020 as: February 20, April 23, June 25, August 27, October 22, and December 17**

Mr. Helm moved to approve on setting the regular Trust Meeting Dates for 2020 as: February 20, April 23, June 25, August 27, October 22, and December 17. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

- (c) Acknowledgement of the Saint Francis Health System (“SFHS”) 2019 Letter from Mr. Jake Henry to the Oklahoma State University Medical Trust Board of Trustees regarding the 2019 accomplishments achieved for the Hospital under the Management of SFHS**

On behalf of the Trustees, Chairman Keller expressed appreciation of thanks and acknowledged the Saint Francis Health System (“SFHS”) 2019 Letter from Mr. Jake Henry to the Oklahoma State University Medical Trust Board of Trustees regarding the 2019 accomplishments achieved for the Hospital under the Management of SFHS.

VI. Joint Conference Committee - Kayse Shrum, DO, Trustee (ATTACHMENT 4)

At Chairman Keller’s request and in Dr. Shrum’s absence, Dr. Blankenship reviewed and discussed section items (a) through (f) detailed below with the Trustees and reported that all items had been thoroughly discussed, reviewed and had received the recommended departmental approval, Hospital committee approval, Medical Executive Committee approval and Joint Conference Committee approval as required.

After lengthy discussion, Mr. Helm moved to approve the Joint Conference Committee’s section of items (a) through (f) detailed below and as recommended by the Medical Executive Committee. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

- (a) Discussion, consideration and possible vote to approve the Organized Medical Staff Appointments and Credentials (Initial and Renewal), Additional Privilege Requests, Staff Status Changes, and Resignations**

Discussion, review and a combined motion for approval was made and approved for this item in the paragraph immediately preceding Agenda Item VI.(a).

- (b) Discussion, consideration and possible vote to approve the New Performance Improvement Moderate Sedation PDSA Action Plans for the following Departments: Emergency Department, Endoscopy, Cath Lab, Intensive Care Unit and Interventional Radiology**

Discussion, review and a combined motion for approval was made and approved for this item in the paragraph immediately preceding Agenda Item VI.(a).

- (c) Discussion, consideration and possible vote to approve the Calendar Year 2018 Infection Prevention Report**

Discussion, review and a combined motion for approval was made and approved for this item in the paragraph immediately preceding Agenda Item VI.(a).

- (d) Discussion, consideration and possible vote to approve the Contract Evaluation Results for 2018**

Discussion, review and a combined motion for approval was made and approved for this item in the paragraph immediately preceding Agenda Item VI.(a).

- (e) Quality Reports attached and available for review: Quality Reports: Quality Dashboard, and OSUMC Pay for Performance Action Plan Updates**

Dr. Blankenship advised that the Quality Dashboard and OSUM Pay for Performance Action Plan Updates were available for review. Inquiry was made regarding providing headlines on the Quality Dashboard. Ms. Hanan advised that details of the Quality Dashboard would be given in her Quality Report under Agenda Item VII.(b).

- (f) Committee Minutes Available for Review from various committees to the Joint Conference: Committee Minutes from the MEC Meeting of September 18, 2019 - Pharmacy and Therapeutics Committee, Quality Council, Utilization Review Committee, Transfusion Review Committee, Safety Committee with FY2020 Safety Committee Dashboard, Infection Control Committee and Medical Executive Committee; and Committee Minutes from the MEC meeting of October 16, 2019 - Pharmacy and Therapeutics Committee, Quality Council, Utilization Review Committee, and Transfusion Review Committee**

Dr. Blankenship reported on the various committees that provided minutes for review by the Medical Executive Committee and Joint Conference Committee.

VII. Oklahoma State University Medical Center Strategic Initiative Reports and Administrator Update

- (a) ACGME Transition Team**

Ms. Davidson provided an update on the ACGME accreditation status of the OSU Medical Center residency programs. Discussion ensued regarding reasons for the accreditation change from AOA to ACGME, change required to be completed by December 2020. At

Trustee Corbett's request, the percentage of applicant matches identified as being "in state" would be provided.

(b) Clinical & Service Quality Improvement Team

In Dr. Baker's absence, Ms. Hanan provided an update on HCAPHS scores and patient safety projects, CMS dashboard improvement scores, ongoing readiness work regarding Hospital readmissions, ongoing work for upcoming EPIC implementation. Discussion ensued.

(c) Network Cohesion Team

Mr. Griffith provided the following report that included based on a rolling year, discussion of referral tracking and results; discussion of out of network referrals, clinic to clinic referrals, clinic to hospital referrals, zero referrals, opportunity referrals and results; cohesion a significant focus. A lengthy discussion ensued.

(d) Vacated Space Team

Mr. Adams provided the following report that included: CMS certification for the outpatient dialysis unit was received October 10, 2019 with an effective date of August, 2019 and update on number of patients and continued marketing efforts, and provided pictures of the outpatient dialysis unit; skilled nursing facility ("SNF") demolition completed with construction ongoing, an update provided on 10/3/19 inspection meeting and upcoming interim inspection on 12/3/19 with the State, and update on submission of reports on suspended SNF license. Mr. Adams also provided pictures of the SNF mock up areas to the Trustees.

(e) FQHC Team

Mr. Adams reported on 8/28/19 meeting with Community Health Connection coordinator regarding mammography referrals and feasibility for Hospital with large amount of self-pay referrals; work progresses on scheduling meeting with chief executive officer at Northeastern Oklahoma Community Health in Hulbert and with chief executive officer at Indian Healthcare Resource Center. Discussion ensued.

(f) Service Portfolio Team

Mr. Adams provided the following report: update provided on Facility's pain management physician, cosmetic/plastics/wound care physician; update on recruitment of urology physician and urology coverage with a Tulsa urology group; update on Hospital physician being trained to perform a TIF procedure for patients with GERD.

(g) Administrator Update

Mr. Adams provided the following report: extended Congratulations to Dr. Shrum for receiving the Journal Record Woman of the Year 2019 Award; update on progress of building exterior and provided pictures to the Trustees; update on upcoming EPIC build

phase and implementation; the Healthcare Facilities Accreditation Program (“HFAP”) resurvey was held on 10/16/19 and cleared, and a three-year accreditation was received; update on various tribal nations provided; clinic update given on midwives, physicians and new clinics and provided pictures to the Trustees of marketing midwife event; update on new medical transcription that will be integrating with EPIC; rapid access transfers update; elevator modernization update given; September town halls scheduled at the Hospital were completed; and update on the Hospital’s nursing recruitment. Lengthy discussion ensued.

VIII. Unfinished Business – Ed Keller, Chairman

None.

IX. New Business (Limited to Matters Not Known About and Which Could Not Have Been Reasonably Foreseen Prior to Posting of the Agenda) – Ed Keller, Chairman

None.

X. Announcements (if any) – Ed Keller, Chairman

- (a) Next regularly-scheduled Trust meeting: December 12, 2019 at OSU Medical Center, 2nd Floor Board Room, 744 West 9th Street, Tulsa**

No additional announcements were given.

XI. Executive Session – Ed Keller, Chairman

- (a) Discussion, consideration and possible vote to authorize and convene an Executive Session, as authorized by Title 25, Oklahoma Statutes, Section 307(B)(4), for the purpose of reporting confidential communications of the Hospital’s Risk Management Reports (July-August, 2019) to the Trust and Trust Counsel, and as authorized by Title 25, Oklahoma Statutes, Section 307(B)(7)**

Mr. Helm moved to authorize and convene an Executive Session, as authorized by Title 25, Oklahoma Statutes, Section 307(B)(4), for the purpose of reporting confidential communications of the Hospital’s Risk Management Reports (July-August, 2019) to the Trust and Trust Counsel. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

The Trustees entered into executive session at 3:39 PM and adjourned from executive session at 3:55 PM.

(b) Discussion, consideration and possible vote to adjourn the Executive Session and reconvene to the Regular Trust Meeting

Mr. Evans moved to reconvene the regular Trust Board meeting. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

Chairman Keller invited the public to return to the open Trust meeting and reported that no action was taken during the Executive Session.

XII. Motion and Vote to Recess or Adjourn – Ed Keller, Chairman

Mr. Helm moved to adjourn the meeting. Upon motion duly made and seconded, the recorded vote was:

AYE: Keller, Helm, Steichen, Evans and Corbett

NAY: None

The meeting adjourned at 3:55 PM.

Oklahoma State University Medical Trust

DRAFT

Jay Helm, Secretary



Oklahoma State University
Medical Center

OSUMC OPERATING AND FINANCIAL RESULTS – NOVEMBER 2019

January 7, 2020

Key Volume Statistics Inpatient



Current Month				Year-to-Date		
Actual	Nov Budget	Prior Year		Actual	Budget	Prior Year
410	474	448	Inpatient Admissions	2,035	2,344	2,196
270	324	326	Observations	1,543	1,706	1,651
680	798	774	Total Admissions & Observations	3,578	4,050	3,847
61	66	62	Average Daily Census (IP Only)	55	64	60
26	28	35	Total Births	136	166	155

Key Volume Statistics Outpatient



Current Month				Year-to-Date		
Actual	Nov Budget	Prior Year		Actual	Budget	Prior Year
2,461	3,187	2,220	Total Physician Visits	12,373	16,047	9,948
1,635	2,155	1,771	Outpatient Visits	9,074	9,842	9,521
3,049	3,276	3,229	Emergency Room Visits	16,805	16,872	16,877

Key Volume Statistics Surgery



Current Month				Year-to-Date		
Actual	Nov Budget	Prior Year		Actual	Budget	Prior Year
98	154	108	Inpatient	531	737	650
162	142	135	Outpatient	761	623	612
260	296	243	Total Surgeries	1,292	1,360	1,262

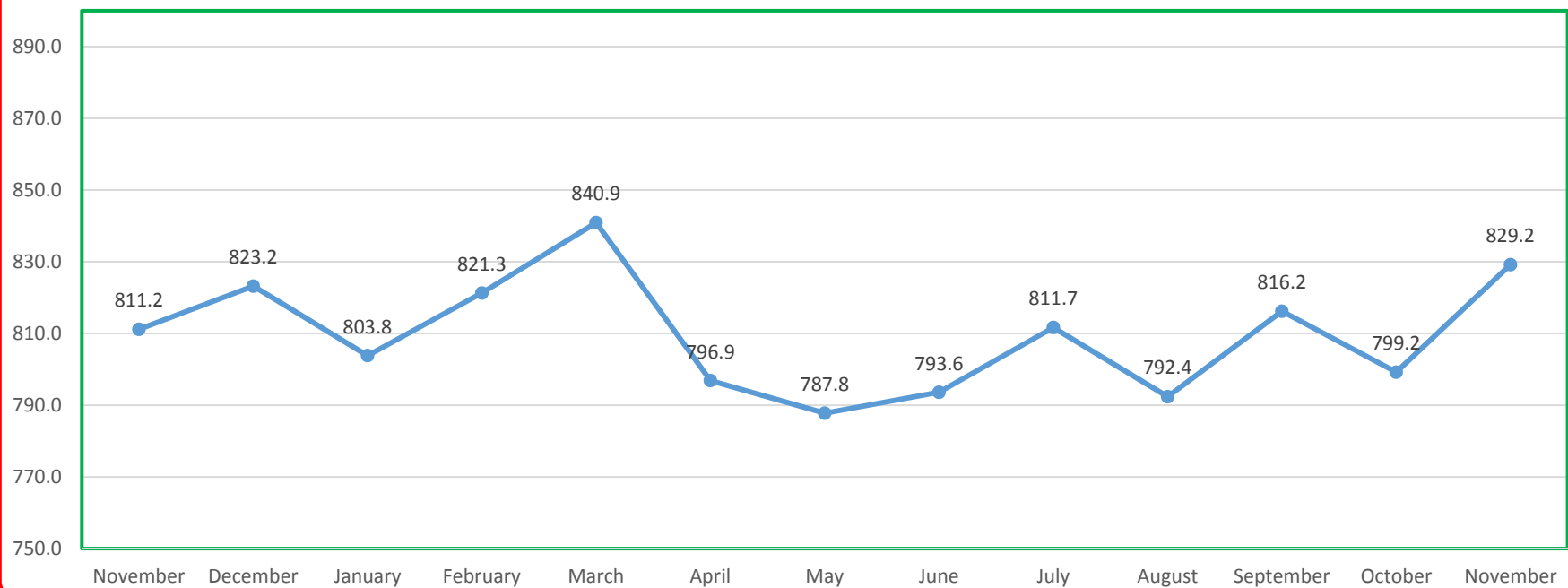
Key Operating Ratios



Current Month				Year-to-Date		
Actual	Nov Budget	Prior Year		Actual	Budget	Prior Year
\$ per Adjusted Discharge						
\$ 6,225	\$ 5,015	\$ 5,199	Labor (excl Phys & Residents)	\$ 5,769	\$ 5,089	\$ 5,281
\$ 474	\$ 460	\$ 343	Pharmacy and Drug Supplies	\$ 403	\$ 453	\$ 406
\$ 1,584	\$ 1,337	\$ 1,242	Medical Supplies	\$ 1,415	\$ 1,348	\$ 1,305
\$ 2,057	\$ 1,797	\$ 1,585	Total Medical Supplies/Pharmacy	\$ 1,818	\$ 1,801	\$ 1,710
8.0	7.1	7.9	Paid FTE's/AOB	8.0	7.3	7.9
4.45	4.20	4.20	ALOS - Acute	4.14	4.17	4.17
1.70	1.66	1.67	Case Mix Index	1.60	1.66	1.65

Paid FTEs Trended

PAID FTE's (less employed physicians & residents)



Key Financial Ratios



Current Month				Year-to-Date		
Actual	Nov Budget	Prior Year		Actual	Budget	Prior Year
-7.7%	2.6%	6.9%	Excess Margin	-5.3%	2.0%	3.3%
95	90	116	Days Cash on Hand	100	90	121
9.72%	5.93%	15.05%	Debt to Capitalization	9.72%	5.93%	15.05%
\$ (756,609)	\$ 286,920	\$ 772,912	Excess Revenue over Expense	\$ (2,598,437)	\$ 1,055,914	\$ 1,750,270



Oklahoma State University
Medical Center

OSUMC OPERATING AND FINANCIAL RESULTS – NOVEMBER 2019

January 7, 2020

OSU MEDICAL CENTER
BOARD OF TRUSTEES REPORT
DECEMBER 2019

CREDENTIALS COMMITTEE REPORT FOR OCTOBER 10, 2019
PRESENTED TO THE MEDICAL EXECUTIVE COMMITTEE ON OCTOBER 16, 2019

INITIAL APPOINTMENTS

Cameron Smith, DO
Specialty: Radiology
Staff Category: Provisional Active Staff
Proctor: Stephen Back, DO

A motion was made, seconded, and carried that the Medical Executive Committee accept the recommendations of the Credentials Committee and the above listed physicians and or allied health professionals be appointed to the professional/allied health staff in the departments and categories indicated with privileges as requested.

REAPPOINTMENTS

FAMILY MEDICINE DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Andrea McEachern, DO – Active Referral Staff

INTERNAL MEDICINE DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Nadim Daher, MD – Active Staff
Sohail Kareem, DO – Courtesy Staff
Steve Kim, DO – Active Staff
Daniel Wildes, DO – Active Staff

OTOLARYNGOLOGY DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Scott Reeder, DO – Active Staff

PEDIATRIC DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Shawna Duncan, DO – Courtesy Staff

PSYCHIATRY DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Jason Beaman, DO – Active Staff

**OSU MEDICAL CENTER
BOARD OF TRUSTEES REPORT
DECEMBER 2019**

RADIOLOGY DEPARTMENT

Reappoint the following providers with privileges granted as requested:

Ralph Noah, MD – Telemedicine Staff

A motion was made, seconded, and carried that the Medical Executive Committee accept the recommendations of the Credentials Committee and the above listed physicians and or allied health professionals be reappointed to the professional/allied health staff in the departments and categories indicated with privileges as requested.

TEMPORARY PRIVILEGES

PATHOLOGY DEPARTMENT

Robert Byrd, MD – Temporary Privileges
Tamara Chaney, MD – Temporary Privileges
Neil Fuehrer, MD – Temporary Privileges
Ashley Gable, MD – Temporary Privileges
Henry Haskell, MD – Temporary Privileges
Anne Herdman Royal, MD – Temporary Privileges
Cynthia Holmes, MD – Temporary Privileges
Luis Soto, MD – Temporary Privileges
Christopher Thompson, MD – Temporary Privileges
Laura Van Newkirk, MD – Temporary Privileges
Sigrid Wayne, MD – Temporary Privileges

A motion was made, seconded, and carried that the Medical Executive Committee accept the recommendations of the Credentials Committee and the above listed physicians and or allied health professionals be granted temporary privileges.

END OF REPORT



MEDICAL CENTER

Origination: 06/2017
Effective: Upon Approval
Last Approved: N/A
Last Revised: 10/2019
Next Review: 1 year after approval
Owner: Billy Byrd: DIR - SECURITY
Department: Emergency Preparedness
Tags:

Emergency Operation Plan (EOP)

PURPOSE

The purpose of the plan is to describe a comprehensive approach to meeting the health, safety, and security needs of the staff and patient population during an emergency situation (Code Yellow) at Oklahoma State University Medical Center (OSUMC).

The plan provides for planning, procedures, communication, training and testing for continuity of operations during and immediately after an emergency.

The plan describes coordination with the community emergency response agencies and other healthcare facilities during an emergency.

Definitions

Code Yellow - An Emergency (or disaster) event that can affect the facility internally as well as the overall target population or the community at large. Emergencies can be internal, man-made, or natural events, and can be small or large events that have the potential to:

- Significantly disrupt the environment of care (e.g. damage to building/ground due to severe winds, storms, fire or earthquakes)
- Significantly disrupt care, treatment, and/or essential services (e.g. Loss of utilities (such as power, water, fuel, etc.), medical supplies (including medications and/or medical gases), communications (including cyber-attacks) within the hospital or community)
- Result in sudden, significantly increased demands for hospital services (e.g. bioterrorist attack, building collapse, pandemic, etc.)

Policy

Organization and Structure: (HFAP -09.00.01, 09.00.02, 09.00.03)

Oklahoma State University Medical Center (OSUMC) helps mitigate the effects of emergency situation through the establishment of a dedicated organizational structure that assures ongoing attention to emergency management planning.

The Safety Committee serves as the oversight committee for emergency management planning. The Safety committee is a multidisciplinary committee and reports to the Oklahoma State University Medical Trust.

The completed Hazard Vulnerability Analysis (HVA) and the Emergency Operations Plan (EOP) are reviewed and approved annually by the Safety Committee, Quality Council, and the Oklahoma State University Medical Trust (OSUMT). (HFAP-09-01.01). Policies referenced in the EOP will go through their usual approval process on an annual basis with the addition of review and approval by the Safety Committee.

The EOP uses an all hazards approach to emergency management and may be applied to any situation. The EOP is based on priorities established in the annual HVA, facility based and community based risk assessment, as well as lessons learned from both actual emergencies and planned training exercises to determine strategies and activities to reduce the risk associated with emergency events. (HFAP -09.00.02)See - HVA Policy.

Additional plans and policies are in place for incident specific emergencies encountered in healthcare and contain more detailed procedures and responses. Those plans/policies are listed in the Policy and Procedure section of this policy. (HFAP 09.01.01)

Location of Plans: The EOP and all referenced policies in the plan are available to staff via PolicyStat. PolicyStat is a hosted solution and is available via internet. In case of complete failure of computer system, a paper copy of the EOP and referenced policies are kept in the Security Dispatch and on the Incident Command Cart.

The EOP is shared with the community emergency response agencies. Documentation of efforts to share EOP with community response agencies are reported to the Safety Committee by the Director of Security and Emergency Management.

Emergency Management is integrated into the facility Quality Assurance and Performance Improvement (QAPI) Plan. Results of After Action Reports (AAR) are reported to the Safety Committee and to the Quality Council Committee at least twice per year. The AARs are utilized to identify gaps and areas for improvement to the EOP.(HFAP 09.00.03).

COORDINATION WITH LOCAL RESPONSE AUTHORITIES: OSUMC participates with other local hospitals and with the Regional Medical Response System (RMRS) to aid in the development, implementation, and notification of a community-wide disaster plan. This plan is designed to provide a coordinated effort, to assure essential medical services in the event of a community disaster. OSUMC is an active member of the Senior Advisory Committee of the RMRS. The Director of Security and Emergency Management attends planning meetings with RMRS and other area hospitals for planning.

OSUMC participates in drills and exercises done by RMRS with activation of the Incident Command System (ICS). An AAR is completed to evaluate response. The Safety Committee uses the information to improve the

hospital's capability to respond to emergencies, and to make improvements to the EOP. (HFAP–09.00.07)

Communication with emergency agencies and other medical facilities, during times of emergency; is coordinated through the WebEOC (Web based Emergency Operations Center) and the RMRS using traditional landline (Phone number 918-596-3100), cell phone, 800 MHz radio, and HAM radio operators who will be stationed at OSUMC as needed for the response. The **Emergency Communications Plan** identifies community resources along with contact information. See **Communications Plan Policy** for additional guidance on internal and external communication during a Code Yellow – Emergency event. (HFAP **09.02.06**)(HFAP-09.02.07) (HFAP 09.02.01)

Medical documentation continues in the Electronic Medical Record (EMR) during an emergency event. Should power be interrupted, documentation will occur on paper with normal downtime procedures initiated. (HFAP 09.01.08)

The type of services OSUMC has the ability to provide in an emergency are listed in the Plan for Provision of Care and Services Policy. During an emergency situation, the ICS is initiated at the hospital to assess and determine responses needed, depending on type of emergency, to safeguard human resources, maintain business operations, and protect physical resources to provide for continuity of healthcare services during an emergency. (HFAP-09.00.05)(HFAP-09.00.04)

The OSUMC ICS is designed after the FEMA and City of Tulsa's Emergency Services Incident Command System and the federal National Incident Management System (NIMS). This assists in assuring that the use of common titles, terminology, communications, organization and structure are similar. The system is designed to flex and expand to meet the needs of the incident. (HFAP-09.00.06)(HFAP 09.01.14)

There may be partial activation of the command center that is done for events that are not large enough in scale or duration or events occurring that may have to potential to have an impact on Hospital services. A partial activation will be initiated by notification to key staff required to facilitate planning of response to event.

The EOP and/or ICS may be initiated by:

1. An Executive Officer (Administrator, Executive Director of Finance, Executive Director of Nursing)
2. Administrator-on-Call (AOC)
3. The Safety Officer
4. The Director of Security and Emergency Management
5. The Facilities Director (for major utilities failures)
6. The House Supervisor , in the absence of the Executive Officer or the Administrator-on-call, or, if there is an "obvious need"

The ranking person outlined above shall function as the Incident Commander until the Executive Officer/or designee (Administrator-on-call) arrives. The Executive Officer /or designee may choose to assume responsibility as the Incident Commander upon arrival at the facility. A decision may be made to alter this responsibility depending on the situation and area of expertise needed to handle the incident. A detailed briefing will be completed as part of this transition. (HFAP-09.00.05)

The Doctor's Conference room on the 2nd floor is utilized for the Incident Command Center location. See the **Incident Command System Plan** for specific procedures related to functioning of the Command Center. (HFAP 09.01.14)

Patient tracking is done through the electronic medical record utilizing the reports available to track location

and disposition of patients. See the **Incident Command System Plan** for additional information on patient tracking.

In the event that a department or the facility will need to evacuate to an alternate location, the Incident Command will track this relocation. See the **Incident Command System Plan** for additional information for employee tracking.

Staffing for Emergencies – Preparedness planning is recognized as a shared responsibility between leadership and staff to ensure there is adequate staffing during emergencies. Staff may be called in for duty immediately or be scheduled for future shifts during the emergency as determined by the Incident Commander. All approved Paid Time Off (PTO) days during an event may be cancelled. Employees should be available to report for duty if it is safe and feasible to do so.

Only current volunteers with OSUMC who have completed the on-boarding process, including orientation to the facility, will be utilized during an emergency. OSUMC will maximize our staff availability and utilize our approved staffing registries to supplement staffing needs during an emergency. Through the emergency management protocols of our local area, we may integrate State and/or federally designated health care professionals to address surge needs or prolonged duration of an emergency. Contact information for the Oklahoma Medical Reserve Corps (OKMRC): <https://www.okmrc.org/> (09.01.09)

OSUMC is prepared to shelter in place should the need arise when an evacuation is not feasible. With the plans set forth for emergency preparedness and activation of the ICS for implementation and management of the plan, OSUMC can maintain operations for patients and staff remaining in the facility during an emergency event for at least 72 hours. See **Shelter-in-Place Policy**. (HFAP 09.01.07)

(HFAP-09.01.03)

During an emergency event, the facility may see a rapid influx of patients. The Incident Commander will be notified in the event there a large number of casualties that may need to be transferred. The Incident Commander will designate a Transfer Officer. The Transfer Officer must work closely with Medical Command at RMRS to ensure EMTALA regulations are addressed including acceptance by a Physician at the receiving hospital. EMTALA remains in effect until formally waived by the federal government. **The Mass Casualties Plan** will be utilized and includes the procedure for triage during the rapid influx of patients. (HFAP-09.00.04)

OSUMC does receive emergency patients and could encounter a patient that has been exposed to chemical, biological, and/or radioactive contamination. The **Hazardous Materials Contaminated Patient Policy** contains procedures for emergency decontamination.(HFAP 09.01.13)

It shall be the responsibility of the Incident Commander to contact the designated alternate sites to determine how many beds are available. The RMRS will also assist in locating receiving facilities. They can be contacted by calling (918-596-3100).

In the event of limitations or cessation of operations, transfer agreements are in place with Saint Francis Hospital, Hillcrest Hospital, and St. Johns Hospital as needed for patient transfers. The nurse managers would be responsible for evaluating patients, in collaboration with Medical staff, required transfer related to limitations or cessation of a needed service. (**See policy – Admit, Transfer of Inpatients, Transfer of Patients from OSUMC and Change in Level of Care; See Emergency Communications Plan**)

(HFAP 09.01.10)

Evacuation of the hospital is not anticipated in most cases, as the risk to patients is increased. Evacuation shall only be considered as a last resort. Should it become necessary to evacuate all or part of OSUMC to

protect the facility's employees, patients, and visitors refer to the **Disaster Evacuation Policy** to guide proper methods to evacuate patients, visitor, and employees from all or part of the building. (HFAP 09.01.06)

In the event the other facilities are unable to accept our patients and/or are affected by the same event causing the evacuation, RMRS will assist in identifying and accessing alternate locations.

The Incident Commander and the Liaison Officer will work with the RMRS to coordinate such an effort. Vendors will be advised to deliver supplies to the site, coordinated by the Director of Materials Management/designee.(HFAP-09.01.06)

Emergency response considerations are given to at-risk populations who are currently in the hospital at the time of an emergency or who may seek medical assistance during an emergency. At-risk populations include individuals with disabilities, are from diverse cultures, have limited English proficiency or are no-English speaking, lack transportation, have chronic medical disorders, have pharmacological dependency, and children, pregnant women and senior-citizens. Also taken into consideration during an emergency is the mobility of patients during an evacuation procedure. Those with limited mobility will be identified and additional assistance provided for evacuation. For more specific information/interventions regarding populations at-risk during an emergency - see policies: (HFAP 09.00.04)

Accommodating Communicative Differences

Disaster Evacuation Policy – Code 100

1135 Waivers (Federally Declared Disasters) - When the President of the United States declares a disaster and the HHS Secretary declares a public involving an 1135 Waiver, OSUMC coordinates with RMRS and other health facilities to arrange for care at alternate locations should evacuation become necessary. These arrangements also address the receipt of residents, when feasible, from other facilities unable to continue their operations. This will allow hospital to provide services in good faith to be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Once an 1135 waiver is authorized, OSUMC may submit requests to operate under that authority to the CMS Regional Office with a copy to HFAP. Approval for submission of the request is made by OSUMC's Administrator or their designee.(HFAP 09.01.11)

In the event of a major disaster involving an 1135 Waiver, this facility will coordinate with and follow instructions from the local response authorities, State Survey Agency, and Federal authorities regarding alternate care sites, or other provisions applicable under that Waiver.

Security of Facility

To provide and maintain the integrity of facility security during any major internal or external incident, locking down of the facility is of the utmost priority. The Security Department may lock down the facility during any Code Yellow Phase 2 situation. This shall be done by a manual or mechanical locking down of the facilities access locking system. At no time, will the method of locking down the facility prevent emergency egress.

If deemed necessary, all exterior doors will be locked with the exception of the Emergency Department. A Security Officer will be posted at that location to monitor and authorize passage. During any Code Yellow Phase 2, only employees with proper Oklahoma State University Medical Center ID badges will be allowed access. Unless directed specifically by the Incident Commander, no visitors will be allowed access into the facility.

The Maternal Child Health Unit will remain locked during emergency operations.

Supply Security - If a department closes during the emergency, supplies should be secured prior to vacating the area. The Material Management area and the Pharmacy will remain locked in an emergency with limited access to prevent loss of needed supplies.

In the event of a major community wide disaster, Tulsa Police or Tulsa County Sheriff may provide supplemental support in the security of this facility. Their direction will fall under the authority of the OSUMC Incident Commander.(HFAP-09.01.12)

The Engineer-on-Duty (EOD) or Facilities Services staff shall secure the Plant, to ensure continued operation of the HVAC equipment.

See **Security Management Plan** for additional security information.

An **Emergency Communications Plan** is available to provide guidance for communication both internally and externally during a Code Yellow Emergency. The plan is a central location for external phone number/contact information for the replenishment of supplies for continuity of care and services in an emergency.

The **Utilities Systems Management Plan** establishes procedures for utility system maintenance, inspection, testing and utility failure emergency response procedures. The **Utilities Contingency Plan** provides steps taken for disruption in utilities during an emergency event.

Training and Testing

Education and training, including drills and exercises, are utilized to achieve proficiency during emergency response and ensure the effectiveness of our EOP.

OSUMC provides initial training on the EOP during the orientation of new staff, and annually to all staff, individuals providing services under contract, and volunteers consistent with their role in the response.

NIMS training is completed by Administration, Directors, Managers, and House Supervisors for increased knowledge to function in the ICS.

Disaster drill exercises are done at least 2 times per calendar year to test the EOP and build staff competencies. The exercises are based on one of the identified HVA hazards. One drill must be a full-scale exercise that is community based and the second is a full-scale exercise that is facility-based full-scale exercise. Free standing ambulatory facilities that are part of the hospital system will participate in two emergency exercises per calendar year. (HFAP 09.03.02)

Actual events, natural or man-made emergencies that required activation of the emergency plan may count as a drill.

AARs will be completed and reported to Safety Committee and to the Quality Council. The Safety Committee uses the information to improve the hospital's capability to respond to emergencies, and to make improvements to the EOP.

POLICIES AND PROCEDURE

Policies and Procedure supporting the EOP or incident specific response plans addressing key response measures are listed below:

Supporting Policies

~~Hazard Vulnerability Policy~~ [Hazard Vulnerability Analysis \(HVA\) Policy](#)

~~Nutritional Services Emergency Policy~~ [Nutritional Services Emergency Preparedness](#)

~~Emergency Preparedness in Materials Management~~ [Emergency Preparedness in Materials Management](#)
~~Security Management Plan~~ [Security Management Plan](#)
~~Utility Management Plan~~ [Utility Systems Management Plan](#)
~~Utilities Contingency Plan~~ [Utilities Contingency Plan](#)
~~Emergency Communications Plan~~ [Emergency Communications Plan](#)
~~Incident Command System Plan~~ [Incident Command System Plan](#)
~~Disaster Evacuation Policy — Code 100~~ [Disaster Evacuation Policy - Code 100](#)
~~Pharmacy Plan~~ [Pharmacy Disaster Preparation](#)

Incident Specific Plans:

~~Severe Weather Policy — Code Black — Stages I and II~~ [Severe Weather Policy - Code Black - Stages I and II](#)
~~Fire Response Plan (Code Red)~~ [Fire Response Plan \(Code Red\)](#)
~~Hazardous Materials Contaminated Patient Policy~~ [Hazardous Materials Contaminated Patient Policy](#)
~~Radiation Contamination Plan~~
[Monitoring of Radiation Exposure \(Personnel Dosimetry Program\)](#)
~~Spill Response for Hazardous Waste, Infectious Waste, Chemotherapy and Radioisotopes~~ [Spill Response for Hazardous Waste, Infectious Waste, Chemotherapy and Radioisotopes](#)

Associated Policies

~~Accommodating Communicative Differences~~ [Accommodating Communicative Differences](#)
~~Admit, Transfer of Inpatients, Transfer of Patients from OSUMC and Change in Level of~~ [Admit, Transfer of Inpatients, Transfer of Patients from OSUMC and Change in Level of Care Policy](#)
~~Care Policy~~
~~Release of Information Guidelines for the Release of Medical Records Information~~ [Release of Information - Guidelines for the Release of Medical Records Information](#)
~~Hazardous Materials/Waste Management Program~~ [Hazardous Materials/Waste Management Program](#)

All revision dates:

10/2019, 09/2019, 06/2019, 06/2017

Attachments:

[Bomb Threat Reporting Form](#)

Approval Signatures

Step Description	Approver	Date
Trust	Edward Keller: OSU Medical Trust Chairman	pending
Trust	Susan Reed: ASST - EXEC - SR	12/2019
Trust	Bettye Paynter: ASST - EXEC - CEO [SR]	12/2019
Administrator	Matthew Adams: HR ONLY	12/2019

Step Description	Approver	Date
Executive Director of Nursing	Rhonda Hanan: HR ONLY	12/2019
MEC / Chief of Staff	Dennis Blankenship: Physician – View Only	12/2019
MEC / Chief of Staff	Shannon Knight: COORD - MEDICAL STAFF	12/2019
Quality Council	Damon Baker: Physician – View Only	12/2019
Quality Council	Jamie Flower: MGR - QUALITY	11/2019
Safety Committee	Susan Reed: ASST - EXEC - SR	11/2019
Safety Committee	Glen Cherry: DIR - FACILITIES	11/2019
	Billy Byrd: DIR - SECURITY	10/2019

COPY

Euality Improvement Measure

Date: 10/16/2019/~~~~~**Dept:** Emergency Dept.

Contact: Amalia Gilley BSN,RN

Check if the issue is: X High Risk High Volume X Problem Prone

; **Goal** The Emergency Dept. will document moderate sedation processes with aim of greater than 90% accuracy.

Measure Details

Baseline: Required components of documentation are the following: 1) Nursing ASA Class Doc; 2) Nursing NPO status doc; 3) Baseline LOC (RSS) Doc; 4) Baseline temp doc; 5) Baseline Pain score doc; 6) V/S monitored per policy (intra and post) 7) RSS score and pain score doc during medication administration; 8) Aldrete score q15 mins until D/C recovery; and 9) Sedation Review Sheets submitted.

Numerator:

Denominator:

Exclusions: Mild and Deep sedation

Benchmark(s):

90% or greater with accuracy and compliance with documentation of moderate sedation with all components of documentation fields.

Benefits:

Improve patient outcomes and compliance with regulatory agencies reporting.

Timeframe:

From 10/2019 to 10/2020

Clinical Indication:

Currently, the emergency department is having difficulty with managing accuracy of 90% or greater with documentation of moderate sedation.

Work:

The current process is very problematic and pose great risk for documentation errors and potential risks for delivering high quality of care for the patient. If we had a form that is all-inclusive it will improve confidence in documentation. It will also allow an all in one global view of the process and will allow the nurse to care for the patient with less

documentation toggling back in forth distractions. Hard stops would fix the fall out if required documentation, such as Aldrete, ASAs, NPO status, baseline LOC (RSS), baseline temperature, baseline pain assessment.

This is required documentation for all areas performing the sedation process, per hospital policy. It will help ensure documentation is fully addressed during highly stressful and high acuity sedation situations.

There has been past instances where there was a 1-minute difference in charting of vitals. I hope that we can set some exclusion criteria. It has been reported by nurses during their "Just in time Training", that they are troubleshooting the monitors and are trying to obtain BPs. Once they are able to obtain vitals, they record real time documentation. The nurses are recording accurate timing of vitals obtained and are being penalized for often times failed equipment errors. The staff report feelings of pressure to document false information due to strict documentation guidelines. In the event that the patient wishes to leave prior to 1-hour time limit, I would hope that we look to approve departure as long as they have returned to baseline and all required areas and no reversal agents are used.

Often times patients are held in their eyes a very long time since med was given and they are often back to baseline very quickly. When patients are being forced to stay, we run the risk that they would leave on their own without proper discharge teachings. Most of the time they are so ready to leave they are not listening to the instructions given. Some even become very defensive when told they have to wait a certain period of time.

Emergency Dept. nurses are trained in various settings that do not have the same processes as those that take place in the ED. Since the ED does not have enough cases, we have to go to other units to complete competency every 2 years. When they go to other units, the process is extremely different. The setup and documentation process varies. Maybe if we had an education dept. driven competency that will allow the ED staff to be checked off with the ED process it would better prepare them for live situations in the ED.

AIM Statement

The Emergency Dept. will document moderate sedation processes with aim of greater than 90% accuracy.

PI Edit/Retire Measure Form

In order to Edit or Retire a Measure, Complete the Form below and submit to Quality Department. Once approved through Quality Council, email notification will be sent to the contact person listed.

Date: 10/16/19 **Dept:** Emergency Dept

Contact: Amalia Gilley BSN, RN

EDIT the following measure

AIM Statement (the current PI project you are wanting to edit/retire): Edit

By June 30, 2019, the Emergency Department will complete all necessary documentation on 100% of patients who are restrained in the department

What is the change for the measure (i.e. to extend the date, to reduce the goal percentage, to clarify the measure, to retire the measure)?

1) Extend the date for 9 months due to the high volume, high risk nature of the use of restraints as well as EPIC transition. 2) Change the AIM statement to: By June 30, 2020, the Emergency Department Nursing staff will complete all necessary nursing documentation on 100% of patients who are restrained in the department.

If editing the measure, what is the reason (i.e. have not met goal and measure deadline has expired):

May and June of 2019, the ED was 100% complaint with this measure. However, since then were still having fallouts. Primarily due to physician error or omission. My goal is to redirect my energy from nursing and extend my aid to the ER physicians. In the past, I have spoken with the ED physician group and it has shown to be very beneficial. Extending this process is crucial, as it is a hot topic with HFAP and other governing agencies.

If retiring, what is the effective date to retire the measure? N/A

If retiring, how will you hardwire the process or periodically review the process to ensure the goal is maintained?

††If retiring the measure, a new measure is likely needed to replace the one being retired. Please fill out the next page for your new measure.

PI Edit/Retire Measure Form

In order to Edit or Retire a Measure, Complete the Form below and submit to Quality Department. Once approved through Quality Council, email notification will be sent to the contact person listed.

Date: 10/16/19 **Dept:** Emergency Dept

Contact: _____

Amalia Gilley BSN, RN

Retire the following measure

AIM Statement (the current PI project you are wanting to edit/retire): Retire

By August 31, 2018, the Emergency Department will have zero mislabeled blood bank specimens.

What is the change for the measure (i.e. to extend the date, to reduce the goal percentage, to clarify the measure, to retire the measure)? N/A

I would like to retire the measure due to being complaint from 4/2019 to date with no fallouts.

If editing the measure, what is the reason (i.e. have not met goal and measure deadline has expired)

N/A

If retiring, what is the effective date to retire the measure? 10/31/2019

If retiring, how will you hardwire the process or periodically review the process to ensure the goal is maintained?

I would review risk managements carefully daily to ensure that none are the result of discontinuing the auditing measure. We have had no fallouts and have been 100% compliant for the past 6 months.

****If retiring the measure, a new measure is likely needed to replace the one being retired. Please fill out the next page for your new measure.**



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

Facility ID#: 119286 CCN: 370078 Facility Name: Oklahoma State University Medical Center Facility City/State: Tulsa, OK Type of Facility: Acute Care Hospital	Review Type: Reaccreditation Survey Survey Dates: July 8 – 11, 2019 Focused Resurvey: September 16, 2019 # of Conditions: 2	Type of Review: Plan of Correction Follow Up Action: Interim Progress Report due July 8, 2020 Executive Committee: October 2019 Reviewed By: AMH, DS
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Category 1 = Complete response; no Interim Progress Report required.

Category 2 = Plan(s) of Correction/Interim Progress Report acceptable and implemented. The facility must still monitor to achieve and maintain full compliance. No Interim Progress Report is required.

Category 3 = The Plan(s) of Correction/Interim Progress Report is complete but requires evidence of sustained compliance. An Interim Progress Report is required.

STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
1.	04.00.09 Evaluation of Competence		X		
2.	07.00.00 Condition of Participation: Infection Control			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020 for the following standards: 07.01.02 07.01.07 07.01.26
3.	07.01.02 Infection Prevention			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020. The following information should be provided: <ul style="list-style-type: none"> Meeting minutes in reviewing results for Environmental Management Rounding for the months of August 2019 through June 2020. Please highlight applicable areas pertaining to compliance with this standard.



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

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STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
4.	07.01.07 Corrective Action			X	<p>Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020.</p> <p>The following information should be provided:</p> <ul style="list-style-type: none"> Meeting minutes in reviewing results for Environmental Management Rounding for the months of August 2019 through June 2020. <p>Please highlight applicable areas pertaining to compliance with this standard.</p>
5.	07.01.20 Surgical Site Infections		X		
6.	07.01.26 Annual Report			X	<p>Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020.</p> <p>The following information should be provided:</p> <ul style="list-style-type: none"> Meeting minutes in reviewing results for Environmental Management Rounding for the months of August 2019 through June 2020. <p>Please highlight applicable areas pertaining to compliance with this standard.</p>
7.	07.02.08 Cold Sterilization		X		
8.	07.02.11 Environmental Requirements in Decontamination Rooms		X		
9.	07.03.01 Cleaning Products Inventory		X		



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

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STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
10.	08.00.03 Safe Storage of Supplies		X		
11.	09.00.01 Condition of Participation: Emergency Preparedness			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020. The report submitted shall include: <ol style="list-style-type: none"> 1. Copies of the two (2) Emergency Drills performed to test the Emergency Operations Plan (EOP), 2. Evaluations and after-action plans for each of the two drills submitted, 3. Meeting minutes showing that the EOP was reviewed and approved annually noting what changes were made to the plan based on evaluation, 4. And the reporting of Emergency Preparedness evaluations and improvement process to the facility's QUAPI program.
12.	09.00.03 Emergency Operations Plan		X		
13.	09.00.04 Patient Population		X		
14.	09.01.01 Policies and Procedures		X		
15.	09.01.02 Nutritional Services		X		
16.	09.01.03 Supplies		X		
17.	09.01.05 Patient & Staff Tracking		X		
18.	09.01.06 Evacuation		X		
19.	09.01.08 Medical Documentation		X		
20.	09.01.09 Volunteers		X		
21.	09.01.11 Invoking the 1135 Waiver		X		
22.	09.02.01 Communication Plan		X		



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

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STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
23.	09.02.02 Contact Information		X		
24.	09.02.04 Information Sharing		X		
25.	09.02.05 Release of Information		X		
26.	10.01.16 Informed Consent		X		
27.	10.01.17 Adequacy of Available Information		X		
28.	11.07.06 Assessing Risk Prior to Construction			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020. The report submitted shall include: <ol style="list-style-type: none"> The reports for the ICRA/construction rounding findings reported in weekly construction meeting and evidence of reporting to the Safety Committee (monthly) and the Infection Control Meeting (every other month). ALSM compliance analysis is reported through QUAPI process, noting the action(s) and organizational response(s) identified as related to opportunities for improvement.
29.	13.03.03 Water-Based Fire Protection System: Control Valves, Piping, and Hangers		X		
30.	13.03.09 Portable Fire Extinguishers - Installation, Inspection and Maintenance		X		
31.	13.04.01 Fire Rated Barriers	X			
32.	13.04.02 Smoke Barriers	X			
33.	13.04.09 Ceilings		X		
34.	16.00.10 Plan of Care			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020.



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

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STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
					The following information should be provided: <ul style="list-style-type: none"> Monthly audit results monitoring Care plan completion and applicability for the months of August 2019 through June 2020. Please submit data in a format that summarized compliance overtime such as a bar graph, timeline, etc. If meeting minutes are included, highlight applicable areas pertaining to monitoring compliance with this standard.
35.	16.01.01 Preparation and Administration of Drugs			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020. The following information should be provided: <ul style="list-style-type: none"> Monthly audit results monitoring pain reassessment for the months of August 2019 through June 2020. Please submit data in a format that summarized compliance overtime such as a bar graph, timeline, etc. If meeting minutes are included, highlight applicable areas pertaining to monitoring compliance with this standard.
36.	18.00.05 Pre-anesthesia Evaluation			X	Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020. The following information should be provided: <ul style="list-style-type: none"> Monthly audit results monitoring compliance with pre-anesthesia assessments for the months of August 2019 through June 2020.



Survey Progress Report

ASSESSMENT OF HEALTHCARE FACILITIES' RESPONSE TO DEFICIENCIES IDENTIFIED DURING ONSITE SURVEY

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STANDARDS		CATEGORY			COMMENTS / IPR REQUISITES
		1	2	3	
					Please submit data in a format that summarized compliance overtime such as a bar graph, timeline, etc. If meeting minutes are included, highlight applicable areas pertaining to monitoring compliance with this standard.
37.	24.00.12 Emergency Preparedness Plan		X		
38.	24.01.08 Physical Environment			X	<p>Plan of Correction is accepted; however, an Interim Progress Report is required to be submitted by July 8, 2020.</p> <p>The following information should be provided:</p> <ul style="list-style-type: none"> Monthly audit results monitoring diet kitchen rounding for the months of August 2019 through June 2020. <p>Please submit data in a format that summarized compliance overtime such as a bar graph, timeline, etc. If meeting minutes are included, highlight applicable areas pertaining to monitoring compliance with this standard.</p>
39.	24.01.09 Lighting, Ventilation, & Temperature Control		X		
40.	25.01.03 Security of Medications		X		
41.	30.00.09 Standards of Practice		X		
42.	31.00.10 Storage		X		
TOTALS		2	30	10	

ACCREDITATION DECISION

- Accreditation – 3 years with Resurvey within 3 years
- Accreditation – 3 years with Resurvey within 2 years
- Accreditation – 3 years with Resurvey within 1 year
- Continued Accreditation
- Extended Accreditation

**Review of Plan of Correction Reports:
(Check all that apply)**

- Plan of Correction Accepted** - Facility must continue monitoring to achieve completion of the plan. **NO IPR REQUIRED** for those Standards
- Plan of Correction Accepted**; however, an Interim Progress Report is required.
IPR Due Date: July 8, 2020
- Denial of Accreditation

USE ONLY FOR COMPLAINT SURVEYS:

- Continued Accreditation
- Continued Accreditation with IPR
IPR Due:
- Continued Accreditation with 1 Yr Follow-Up Survey
- Revocation of Accreditation

CERTIFICATION DECISION

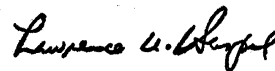
- Certification
Duration: 3 years
- Plan of Correction Acceptable—Facility must continue monitoring to achieve completion of the plan.

**INTERIM PROGRESS REPORTS:
(Check all that apply)**

- Interim Report Accepted---No Further Action Required
- Interim Report Accepted---Additional Interim Report Required.
Due Date:
- Interim Report **NOT** Accepted—Additional IPR required
Due date:

**Plan(s) of Correction / Interim Progress Report Accepted:
09/04/2019**

**Effective Date of Accreditation:
10/04/2019**



**Lawrence U. Haspel, D.O.
Chair, Executive Committee**

Date: 10/02/2019