

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/06/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL NORTHWEST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 12/5/2012 through 12/6/2012</p> <p>Facility Number: 008899</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 12/11/12</p>	S000000	Thank you for your valued input and insight.	
S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 7 contracted services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. Letter of Agreement between Saint Margaret Mercy (SMM) hospital and Kindred Northwest Hospital signed March 6th, 2011 entered into an agreement for SMM to provided the following services: Maintenance Services, Surgery and Minor Procedures, Radiology, X-ray, CT, MRI, EEG, EKG, Nuclear Medicine, and other Radiology Services.</p> <p>2. The Performance Improvement reports were reviewed with staff member #1 and #2. The following</p>	S000406	<p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> · To ensure compliance to the standard, the organization partnered with the Quality Department from the HOST hospital. This partnership aided in the improved communication of quality and performance improvement data. · On January 7, 2013, a meeting was held with the Director of Quality from the HOST hospital, Kindred's Chief Executive Officer and Kindred's Director of Quality. During this meeting a process was establish to make certain that quality data from all contracted services is submitted quarterly. Additionally, historical data for all contracted services was submitted to Kindred's Director of Quality. · To ensure appropriate organization communication and reporting, quality data from the contracted services will be reported to the Quality and Medical Executive Committees. <b>2. How are you going to prevent the deficiency from recurring in the future?</b> · To prevent the deficiency from recurring in the future, the</p>	02/06/2013

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S000554	<p>services were not being evaluated by the Performance Improvement Committee: Laboratory; Laundry/Linen; Magnetic Resonance Imaging (MRI); Nuclear Medicine; Radiology Diagnostic and Therapeutic services; and Surgical/Minor Procedure services.</p> <p>3. At 11:30 AM on 12/6/2012, staff members #1 and #2 confirmed the 7 contracted services identified were not made part of the hospital's comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and</p>		<p>Kindred's Director of Quality will contact the HOST hospital Director of Quality quarterly to obtain quality data for the contracted services. · Also, the Director of Quality from the HOST hospital has set a calendar alert as a reminder to forward data to Kindred's Director of Quality. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> The individual responsible for the above corrective action include: · Chief Executive Officer · Director of Quality (Both Kindred and HOST)4. <b>By what date are you going to have the deficiency corrected?</b> · Completion date: February 6, 2013 a. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases. · Meeting with HOST hospital: January 7, 2013 · Quality Date Received from HOST Hospital: January 7, 2013 · Data to Quality Committee: January 23, 2013 · Data of Medical Executive Committee: January 29, 2013</p>				

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	<p>visitors.</p> <p>Based on observation, policy review, crash cart logs, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage per facility policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>During the tour of the 5th floor patient care unit at 9:25 AM on 12/06/12, accompanied by staff members #A1, A2, and A11, the following items were observed in the crash cart: <ul style="list-style-type: none"> <li>A. One of one Central Venous Cath Kit with an expiration date of 11/2012.</li> <li>B. One of one purple top lab tube with an expiration date of 11/2012.</li> <li>C. One of one yellow top lab tube with an expiration date of 08/2012.</li> <li>D. One of one blue top lab tube with an expiration date of 03/2012.</li> </ul> </li> <li>At 10:00 AM on 12/06/12, staff member #A11 indicated the carts were opened on the 15th of each month and all of the supplies were supposed to be checked at that time. Otherwise, the carts were checked twice daily to ensure they were locked and the other equipment was in place.</li> <li>At 10:30 AM on 12/06/12, four of four containers of Lifescan strips for the</li> </ol>	S000554	<p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> Crash Cart: To correct this deficiency a multidisciplinary team approach was utilized. On Dec. 7, 2012 this team performed a review of the Emergency Medication policy which includes the crash cart process. As result of this policy review, the follow actions were executed: · Review and revision of all Crash Cart Inventory checklists which included: the Medication Checklist, Intubation Box checklist, and Equipment and Supply Checklist. These checklists where made more detailed to include the number of needed supplies, equipment and medication to be included in both crash carts. Also, the medication checklist was revised to make certain that the individual performing the crash cart check can determine, at a glance, what medication are included in the cart as well as their expiration dates. The Intubation Box checklist was updated to ensure clarity. · Development of a monthly Inventory Checklist and schedule to make certain all supplies medication and equipment are available and not expired. This monthly checklist and schedule supports the process for a direct observation audit of all supplies,</p>	02/05/2013			

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	<p>glucometers were observed open, but not dated, on the 6th floor patient care unit. The label directions indicated the strips should be dated and discarded after 4 months.</p> <p>4. The facility policy "Emergency Medications", last revised 11/09, indicated, "2. The emergency drug supply shall remain inside the cart, number sealed, at all times when not in use. The seals will be broken only when an emergency situation arises or when necessary for quality control checks. The cart's contents list shall reside on the outside of the cart and shall include the earliest drug expiration date within the cart. ...1. The contents of the emergency cart should follow current ACLS guidelines. ...3. Patient care units are responsible for checking the integrity of the emergency cart at least daily. This check should include: ...Expiration date on labels for drugs and equipment/supplies."</p> <p>5. The October and November 2012 logs for checking the crash cart, from both patient care units, were reviewed and lacked any documentation to indicate the carts were opened and checked on the 15th of the month or any other specific day.</p>		<p>equipment, and medication ensuring all supplies, equipment and medications are present and not expired. · Audit process to validate compliance. · Education of the Charge Nurse Staff and Lead Respiratory Therapist to ensure clear understanding of the new process. Glucometer: Re-education of all nursing staff to ensure clear understanding of practice for dating glucometer strips once the container is opened. Additionally, the Charge Nurse will dispense all glucometer to the nursing staff to ensure appropriate dates are applied to containers. 2. <b>How are you going to prevent the deficiency from recurring in the future?</b> Crash Cart: The charge nurse will audit the process twice daily to ensure compliance and report any incident of noncompliance to Nursing leadership daily. Glucometer: Charge Nurse will dispense all new Glucometer containers. The Charge nurse will date the container at the time of dispensing. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> The individuals responsible for the above corrective actions: o Chief Clinical Officer o Clinical Educator o Charge Nurse o Lead Respiratory Therapist 4. <b>By what date are you going to have the deficiency corrected?</b> Policy Review: December 7,</p>		

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S000608	<p>6. At 12:30 PM on 12/06/12, staff members #A1 and A11, acknowledged the lack of documentation to ensure that crash carts were checked as per policy and confirmed the other tour findings. They also indicated there was no list of crash cart supplies, but indicated all of the carts should be stocked the same.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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 in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure all health care personnel adhere to the hospital policies on entering an isolation room.</p>	S000608	<p>2012 Change in dispensing Glucometer December 30, 2012 Development of Checklist: January 4, 2013 Education of the staff: January 14, 2013a. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases. Completion Date: February 5, 2013</p> <p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> To ensure compliance of this standard, On January 3, 2013 the Chief Executive Officer and the Medical Director, drafted a letter to the</p>	01/04/2013

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	<p>Findings included:</p> <p>1. At 10:25 AM on 12/6/2012, room #6202 was observed with a sign posted on the door frame indicating before entering the room, all personnel must don a gown and a mask; upon leaving the room, the gown and mask are to be thrown away and hands are to be washed thoroughly. Physician staff member #13 and Nurse Practitioner #14 were observed walking around the patient's bed without a gown or mask. Both staff members were observed wearing their stethoscopes around their necks. After the two practitioners were done examining their patient, Physician staff member #13 was observed exiting the room without washing his/her hands. Neither practitioner was observed disinfecting the stethoscopes. Staff member #13 was observed heading to another patient's room before staff member #2 stopped the practitioner and</p>		<p>Medical Staff as well as all Nurse Practitioners addressing this concern. This letter served as re-education and reinforced of Infection Control practices at Kindred Hospital. 2. <b>How are you going to prevent the deficiency from recurring in the future?</b> To prevent this deficiency from occurring in the future, The Infection Control Practitioner will perform routine direct observations of the Hand Hygiene as well as all appropriate PPE practices. The results will be reported monthly to the Infection Control, Quality and Medical Executive Staff Committees for recommendations and corrective actions as needed. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> The individuals responsible for the above corrective actions: · Chief Executive Officer · Medical Director · Infection Control Practitioner 4. <b>By what date are you going to have the deficiency corrected?</b> January 4, 2013</p>		

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	<p>reminded him/her of the proper standard precautions.</p> <p>2. Contact Precautions policy #H-IC 02-002 states, "Don gloves upon entering a Contact Precautions room. Don gowns upon entry into the room or cubicle whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. (If you have entered the room and now are anticipating direct contact with the patient or the environment, Stop and Don a gown.) Remove and dispose of gown and gloves before leaving the patient's room and perform the appropriate form of hand hygiene. A stethoscope, blood pressure cuff and tourniquet will be dedicated to individual patients. If use of common equipment is unavoidable, then cleaning and disinfecting is necessary upon removal from the room."</p>			

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S000871	<p>3. At 10:50 AM on 12/6/2012, staff member #2 confirmed the practitioners were in the patient's room without gowns or gloves.</p> <p>410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge. (i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or</p>			

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	<p>other responsible individual who shall immediately verify that the read back order is correct.</p> <p>(ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.</p> <p>Based on policy review, medical staff rules and regulations, medical record review, and interview, the facility failed to ensure verbal/telephone orders were authenticated according to policy for 11 of 12 patient records reviewed (#N1- N6 and N8- N12).</p> <p>Findings included:</p> <p>1. The facility policy "General Documentation Guidelines", last revised 08/2012, indicated, "7. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated and their authors identified. ...B. All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. ...C.</p>	S000871	<p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> · To ensure compliance to this standard, on January 3, 2013 the Chief Executive Officer and the Medical Director drafted a letter to the medical staff addressing this concern as it relates to authentication of verbal and telephone orders. Noting that continued noncompliance will be addressed according to Medical Staff By-Laws. · Beginning February 1, 2013, medical record audits on authentication of verbal/telephone orders will be conducted monthly. This process will aid in identifying episodes of noncompliance. <b>2. How are you going to prevent the deficiency from recurring in the future?</b> · The Chief Executive Officer along with the Medical Director will monitor this process. Noted that within the guidelines of the Medical Staff By-Laws pursue disciplinary action will be taken when indicated. · The Director of</p>	02/05/2013			

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	<p>Verbal and telephone orders must be authenticated by the responsible practitioner within the time frame defined in the Medical Staff Rules and Regulations."</p> <p>2. The Medical Staff Rules and Regulations from April 2012 indicated on page 8, "10. All verbal/telephone orders must be dated, timed and signed (authenticated) by the prescribing practitioner. Each entry shall be authenticated (dated, timed, and signed) within 48 hours."</p> <p>3. The medical record for patient #N1 indicated numerous verbal/telephone orders from the physician including: A. Telephone order from 07/15/12, signed by the physician, but not dated or timed. B. Verbal order from 08/08/12, signed by the physician, but not dated or timed. C. Telephone order from 08/09/12, signed by the physician on 08/22/12.</p> <p>4. The medical record for patient #N2 indicated numerous verbal/telephone orders from the physician including: A. Two telephone order from 06/13/12, signed by the physician, but not dated or timed. B. Telephone order from 06/14/12, signed by the physician, but not dated or</p>		<p>Quality will oversee the tracking, trending and analysis of the data. Results will be reported to the Chief Executive Officer, Medical Director, Quality and Medical Executive Committees. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> · Chief Executive Officer: Process Oversight · Medical Director: Medical Staff Oversight · Director of Quality: Data Collection Oversight 4. <b>By what date are you going to have the deficiency corrected?</b> The deficiency will be corrected on February 5, 2013</p>		

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	<p>timed.</p> <p>C. Telephone order from 06/28/12, signed by the physician, but not dated or timed.</p> <p>D. Telephone order from 06/30/12, signed by the physician, but not dated or timed.</p> <p>E. Telephone order from 07/02/12, signed by the physician, but not dated or timed.</p> <p>F. Telephone order from 07/5/12, signed by the physician, but not dated or timed.</p> <p>5. The medical record for patient #N3 indicated numerous verbal/telephone orders from the physician including:</p> <p>A. Telephone order from 05/10/12, signed by the physician, but not dated or timed.</p> <p>B. Telephone order from 05/11/12, signed by the physician, but not dated or timed.</p> <p>C. Verbal order from 05/31/12, signed by the physician, but not dated or timed.</p> <p>D. Telephone order from 06/04/12, signed by the physician, but not dated or timed.</p> <p>E. Telephone orders from 06/14/12, signed by the physician, but not dated or timed.</p> <p>6. The medical record for patient #N4 indicated numerous verbal/telephone orders from the physician including:</p>						

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	<p>A. Four telephone orders from 06/08/12, signed by the physician, but not dated or timed.</p> <p>B. Two telephone orders from 06/08/12, signed by the physician on 07/07/12.</p> <p>7. The medical record for patient #N5 indicated numerous verbal/telephone orders from the physician including:</p> <p>A. Telephone order from 10/09/12, signed by the physician, but not dated or timed.</p> <p>B. Telephone order from 10/12/12, signed by the physician, but not dated or timed.</p> <p>C. Verbal order from 10/14/12, signed by the physician, but not dated or timed.</p> <p>D. Telephone order from 10/15/12, signed by the physician, but not dated or timed.</p> <p>8. The medical record for patient #N6 indicated numerous verbal/telephone orders from the physician including:</p> <p>A. Verbal order from 05/05/12, signed by the physician, but not dated or timed.</p> <p>B. Telephone order from 05/16/12, signed by the physician, but not dated or timed.</p> <p>C. Telephone order from 05/25/12, signed by the physician, but not dated or timed.</p> <p>D. Telephone order from 05/27/12, signed by the physician, but not dated or</p>			

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NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL NORTHWEST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320
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	<p>timed.</p> <p>E. Telephone order from 06/01/12, signed by the physician, but not dated or timed.</p> <p>9. The medical record for patient #N8 indicated numerous verbal/telephone orders from the physician including: A. Telephone order from 08/27/12, signed by the physician, but not dated or timed. B. Telephone order from 08/29/12, signed by the physician, but not dated or timed.</p> <p>10. The medical record for patient #N9 indicated numerous verbal/telephone orders from the physician including: A. Telephone order from 08/17/12, signed by the physician, but not dated or timed. B. Four telephone orders from 08/23/12, signed by the physician, but not dated or timed.</p> <p>11. The medical record for patient #N10 indicated numerous verbal/telephone orders from the physician including: A. Telephone order from 06/21/12, signed by the physician, but not dated or timed. B. Telephone order from 07/02/12, signed by the physician on 08/02/12. C. Telephone order from 07/05/12,</p>			

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	<p>signed by the physician, but not dated or timed.</p> <p>12. The medical record for patient #N11 indicated numerous verbal/telephone orders from the physician including: A. Verbal order from 09/22/12, signed by the physician, but not dated or timed. B. Telephone order from 10/03/12, signed by the physician, but not dated or timed. C. Two telephone orders from 10/09/12, one signed by the physician on 10/31/12 and one signed by the physician, but not dated or timed.</p> <p>13. The medical record for patient #N12 indicated numerous verbal/telephone orders from the physician including: A. Telephone order from 09/15/12, not signed, dated or timed by the practitioner. B. Two telephone orders from 09/20/12, signed by the physician, but not dated or timed.</p> <p>14. At 1:00 PM on 12/06/12, staff members #A1 and A11 confirmed the medical record findings and indicated the orders were not authenticated according to policy and medical staff rules and regulations.</p>			

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to follow their blood transfusion policy for 5 of 5 patients who received transfusions during their hospitalization (#N6, N7, N8, N9, and N10).</p> <p>Findings included:</p> <p>1. The facility policy "Transfusion Therapy", last revised 02/2012, indicated, "2. Vital signs (VS) will be observed and documented at minimum as established by AABB guidelines: Pre-transfusion baseline VS immediately prior to initiation of transfusion. Check VS 15 minutes after start of transfusion. Check VS at the conclusion of the transfusion. Check VS at 1 hour post-transfusion. Additional vital signs may be observed and documented during the transfusion as established by hospital specific policy." The policy did not indicate where to</p>	S000952	<p>1. <b>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> · To ensure compliance to this standard, on December 13, 2012, the Transfusion Therapy policy as well as the Blood Transfusion Record was reviewed. Additionally, the Blood Bank utilized for obtaining blood products is part of the HOST hospital noting that the Blood Transfusion Record is issued through this Blood Bank. · As a result of this review, it was determined the Kindred Transfusion Therapy policy would be revised and an addendum would be added. This addendum supports the Blood Transfusion Record as well as the current practice surrounding monitoring vital signs before during and after a blood transfusion. The addendum to the Transfusion Therapy policy will go before the</p>	02/06/2013

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	<p>document all of the vital signs.</p> <p>2. The medical record for patient #N6 indicated blood transfusions were administered on 05/02/12 and 05/27/12. The Blood Transfusion Records from those dates indicated documentation of pre-transfusion vital signs, 15 minute vital signs, and conclusion vital signs, but lacked documentation of 1 hour post-transfusion vital signs.</p> <p>3. The medical record for patient #N7 indicated two blood transfusions were administered on 07/12/12. The Blood Transfusion Records from that date indicated documentation of pre-transfusion vital signs, 15 minute vital signs, and conclusion vital signs, but lacked documentation of 1 hour post-transfusion vital signs.</p> <p>4. The medical record for patient #N8 indicated blood transfusions were administered on 8/28/12, 09/08/12, and 09/19/12. The Blood Transfusion Records from those dates indicated documentation of pre-transfusion vital signs, 15 minute vital signs, and conclusion vital signs, but lacked documentation of 1 hour post-transfusion vital signs.</p> <p>5. The medical record for patient #N9</p>		<p>following committees for approval: · Patient Care and Safety: January 21, 2013 · Quality Committee: January 23, 2013 · Medical Executive Committee: January 29, 2013 2. How are you going to prevent the deficiency from recurring in the future? To ensure this deficiency does not occur again, the Transfusion Therapy policy has been amended to support the Blood Transfusion record supplied to the organization by the Host hospital's Blood Bank. This amendment also supports the current practice for taking vital sign for a patient receiving a blood transfusion. The addendum reads: Vital signs (VS) will be observed and documented at minimum as established by American Association of Blood Banks (AABB) guidelines: VS Pre transfusion baseline VS 15 mins after start of transfusion VS at the conclusion of the transfusion3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The individuals responsible for the above action plan are: · Chief Clinical Officer · Clinical Nurse Manager 4. By what date are you going to have the deficiency corrected? · Completion Date: February 6, 2013 If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty</p>		

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	<p>indicated blood transfusions were administered on 7/13/12, 07/17/12, 07/28/12, 07/31/12, and 08/22/12. The Blood Transfusion Records from those dates indicated documentation of pre-transfusion vital signs, 15 minute vital signs, and conclusion vital signs, but lacked documentation of 1 hour post-transfusion vital signs.</p> <p>6. The medical record for patient #N10 indicated a blood transfusion was administered on 06/21/12. The Blood Transfusion Record from that date indicated documentation of pre-transfusion vital signs, 15 minute vital signs, and conclusion vital signs, but lacked documentation of 1 hour post-transfusion vital signs.</p> <p>7. At 12:50 PM on 12/06/12, the medical records were reviewed with staff members #A11 and A18 who confirmed the records lacked documentation of the 1 hour post-transfusion vital signs per policy. They indicated the Blood Transfusion Record lacked any specific area for documenting those vital signs. They indicated sometimes the vital signs coincided with the routine vital signs and sometimes nurses recorded them in the notes, but there was no consistent documentation to ensure the vital signs were taken 1 hour after a transfusion.</p>		(30) day phases. · January 6, 2013: Policy addendum created · February 6, 2013: Review and Approval of addendum by all appropriate committees				

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S001114	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1)</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>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on documentation review and staff interview, the facility failed to ensure routine inspections are conducted periodically for evidence of pests per hospital policies and procedures.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Pest Control policy H-IC states, "Routine Inspections are conducted periodically for evidence of pests."</li> <li>2. Pest-Sighting Logs are maintained by Saint Margaret Mercy Hospital. The Pest-Sighting</li> </ol>	S001114	<p>1. <b>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> To ensure this deficiency was corrected the following actions occurred:</p> <ul style="list-style-type: none"> <li>December 13, 2012: Review of the Pest Control policy.</li> <li>December 13, 2012: Review of the Host hospital guidelines for pest control</li> <li>December 13, 2002: Development of an addendum to the Kindred Pest Control policy to ensure alignment of policy and practice. The addendum to the Kindred Pest control policy indicates that "all pest or insect sighting will be reported to the HOST hospital housekeeping/maintenance supervisor or designee".</li> </ul> <p>Additionally, during monthly environmental of care rounds,</p>	02/06/2013

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	<p>Logs revealed 11/6/12 roach was observed, 8/3/12 flies were observed, and 6/1/12 a roach was observed. The logs revealed only 3 days in 2012, the pest control company reacted to staff sightings.</p> <p>3. At 2:15 PM on 12/5/2012, staff member #17 indicated the pest control company is contracted with Saint Margaret Mercy Hospital (SMM) and performs routine weekly inspections for SMM. However, a Pest-Sighting Log will be maintained if anywhere else within SMM has identified an insect or rodent; this would include Kindred Northwest Hospital. The staff member confirmed routine pest control inspections are not conducted for Kindred Northwest Hospital.</p>		<p>routine inspections will be conducted for the present/evidence of pest, insects, rodents or other vermin. This report will include: 1. Type of problem 2. Location 3. Person Reporting the concern 4. Time issue being reported The addendum to the Pest Control policy will go before the following committees for approval: · Patient Care and Safety: January 21, 2013 · Quality Committee: January 23, 2013 · Medical Executive Committee: January 29, 2013 2. <b>How are you going to prevent the deficiency from recurring in the future?</b> To make certain this deficiency does not reoccur in the future, the Pest Control policy was amended to ensure compliance of the standard as practice and policy are now in alignment. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> The responsible individuals: · Kindred Chief Executive Officer · Director of Housekeeping Services 4. <b>By what date are you going to have the deficiency corrected?</b> · Completion Date: February 6, 2013 a. <b>If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.</b> · January 6, 2013: Policy addendum created ·</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in two (2) instances.</p> <p>Findings included:</p> <p>1. Fire Safety Management Plan EC.01.01.01.06 , last reviewed 5/2012, states, "The hospital minimizes the potential for ham from fire, smoke, and other products of combustion."</p>	S001118	<p>February 6, 2013: Review and Approval of addendum by all appropriate committees</p> <p>1. <b>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> To ensure compliance to the standard, the following corrective actions have taken place: · December 6, 2012: The electrical closets on the 5 th and 6 th floors we cleaned, removing all debris that would cause a hazard to patients, public or employees. · January 4, 2013: The Environment of Care Rounding Tool was revised to include direct observation of the 5 th and 6 th Floor Electrical Closets. 2. <b>How are you going to prevent the deficiency from recurring in the future? To ensure compliance and to prevent the deficiency from recurring in the future the</b></p>	01/04/2013			

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S001124	<p>2. At 10:05 AM on 12/6/2012, the 5th floor electrical closet/pipe chase was observed cluttered with cardboard boxes of 4' light bulbs and other supplies. The electrical panel was observed with a paint spray can sitting on top of it and assort debris.</p> <p>3. At 10:45 AM on 12/6/2012, the 6th floor electrical closet/pipe chase was observed with cardboard boxes of supplies and the electrical panel was observed with trash debris on it.</p> <p>4. At 11:00 AM on 12/6/2012, staff member #3 confirmed the 2 electrical closets were messy and should not be storing cardboard boxes in them. The staff member indicated the cluttered room can be a fire safety concern.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall hospital</p>		<p><b>following actions will take place:</b></p> <ul style="list-style-type: none"> <li>· During monthly Environment of Care rounds, the electrical closets will be opened and inspected for cleanliness ensuring a hazard free environment.</li> <li>· The HOST hospital will be contacted during these rounds when any occurrence of a hazardous situation is noted.</li> <li>· Results of the Environmental of Care Rounds will be reported at the EOC committee as well as Quality and Medical Executive Committees as indicated.</li> </ul> <p>3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> Chief Executive Officer Director of Quality</p> <p>4. <b>By what date are you going to have the deficiency corrected?</b> Completion Date: January 4, 2013</p>		

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	<p>environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on document review and staff interview, the facility failed to ensure 40 pneumatic beds the hospital received the Preventive Maintenance criteria for proper operation as per hospital policies and procedures.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Medical Equipment Management Plan EC.01.01.01.07, last reviewed 5/2012, states, "Kindred Hospital provides a safe environment for its patients, visitors, and staff by managing, maintaining, testing, and inspecting all medical equipment before initial use and throughout the life of the equipment."</li> <li>The Letter of Agreement dated March</li> </ol>	S001124	<p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b> To ensure this deficiency was corrected, the following actions took place: · December 7, 2012: Review of all "Bed Rental Check-In Forms" that correlated with the beds in question. · As a result of this review, it was noted that 6 of the 7 elements were checked on the beds. The one omitted item read, "Is the unit functional (all controls, mechanical features and breaks operational)?" · On December 7, 2012: To ensure appropriate PM and equipment operation, 100% of all beds were checked as it relates to the above omission. All beds were found to be in appropriate operational status. <b>2. How are you going to prevent</b></p>	01/04/2013

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	<p>16th, 2011, was an agreement with Saint Margaret Mercy Hospital (SMM) and Kindred Northwest Hospital for SMM provide Bio-Medical Engineering services.</p> <p>3. Kindred Northwest Hospital purchased 40 pneumatic beds for their patient rooms. SMM Maintenance Department checked in the beds on a Bed Rental Check-in Form. The check-in form had 7 lines to check 'YES' or 'NO'. All 40 beds forms lacked any lines checked yes or no (i.e. "Does unit have 3 prongs on the power plug"?)</p> <p>4. At 1:05 PM on 12/5/2012, staff member #2 indicated he/she did not understand why the beds were checked in by SMM on a bed rental form. The staff member also indicated the beds should have been checked if they were operational upon receipt for patient safety.</p>		<p><b>the deficiency from recurring in the future?</b> To make certain this deficiency does not recur in the future, Kindred personnel will perform a real time audit on 100% of "Bed Rental Check-In" documents for completeness and accuracy. As this Kindred employee will be conducting this audit at the time of the maintenance equipment check, this process will aid in ensuring that Kindred equipment is being checked appropriately and thoroughly. 3. <b>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</b> · Chief Executive Officer (Kindred) · Director of Bio-Medical Engineering (HOST Hospital) · Materials Manager (Kindred) 4. <b>By what date are you going to have the deficiency corrected?</b> Completion Date: January 4, 2013</p>		