

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000000	The visit was for a licensure survey. Facility Number: 005113 Survey Date: 1-20/22-15 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Nancy Otten, RN Public Health Nurse Surveyor Steve Poore, BS MLT Medical Surveyor 3 QA: claughlin 02/06/15	S000000		
S000322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015	
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>least triennially.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedure and ensure that all policy/procedures in use were updated and/or reviewed at least every three years by a representative of the facility for 6 of 8 medical record (MR) policy/procedures and 3 administrative policy/procedures provided for review.</p> <p>Findings:</p> <p>1. The administrative policy titled Policy Development and Retention of Revised/Outdated Policies and Procedures (approved 10-12) indicated the following: "All policies and procedures will be developed using the same hospital format ...corporate mandated policies and procedures will be part of the administrative policy and procedure manual ...administrative policies will be signed by the CEO ...at a minimum of every three years, all department policies will be reviewed, revised, and signed ..."</p> <p>2. Review of MR department policy/procedures indicated that the following policies had not been reviewed within the past three years: Unit Medical Record (approved 7-10), Correction of Dictated Reports - Physician (approved</p>	S000322	<p>1. The Deficiency of policies not being reviewed within three years has been corrected. All the listed policies have been reviewed and revised as necessary. Each of the policies reflects the date and year of review. The deficiency for policy not showing adoption at the facility level has been corrected. The policy has been reviewed by the department director and CEO and indicated on the new policy format.</p> <p>2. The HIM Department specific policies and Administrative policies have been added to two (2) year calendar review to prevent policies from not being reviewed according to policy.</p> <p>3. The CQO will be responsible for making sure policies are monitored and reviewed according to policy.</p> <p>4. The CQO will conduct audits of policies to check for compliance with reviewing of policies is being completed and will be reported to Policy and Procedure Committee.</p>	02/10/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015	
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>7-10), Printing Records for a ROI Request (approved 7-10), Faxing Records for a ROI Request (approved 7-10), Completing a ROI Request (approved 7-10), and Right to Access Protected Health Information (approved 5-11).</p> <p>3. During an interview on 1-21-15 at 0935 hours, the director of quality A4 confirmed that the 6 MR policies lacked documentation of approval within the past 3 years.</p> <p>4. The MR policy/procedures titled Right to Access Protected Health Information (approved 5-11) and Confidentiality (approved 5-11) indicated the following: "Affected Departments: Facility Wide: All Providers. Entities: CHS-affiliated Providers ..." The policy/procedure failed to indicate a date of adoption and name of the facility representative authorizing the use of the corporate policies at the licensed facility.</p> <p>5. During an interview on 1-22-15 at 0935 hours, the director of human resources A17 confirmed that the name of the individual approving the Right to Access Protected Health Information policy and the Confidentiality policy is not and has not been employed by the facility.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000596	<p>6. The administrative policy titled Compliance with HIPAA Privacy Regulations, Definitions (approved 8-11) failed to indicate that it had been approved within the past 3 years.</p> <p>7. During an interview on 1-21-15 at 0935 hours, the director of quality A4 confirmed that the administrative policy lacked documentation of approval within the past 3 years.</p> <p>8. The administrative policy titled Completion of Medical Records (approved 2-10) failed to indicate that it had been reviewed or approved within the past 3 years.</p> <p>9. During an interview on 1-21-15 at 0935 hours, the director of quality A4 confirmed that the administrative policy lacked documentation of approval within the past 3 years.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the infection control committee failed to maintain a safe and healthful environment in 5 instances.</p> <p>Findings:</p> <p>1. Review of facility Policy 100-10, last updated 1/13/2015, indicated housekeeping staff are to: M. Disinfect furniture; 1. Interior and exterior parts of cabinet, and 2. drawer, interior and exterior parts of nightstand.</p> <p>2. On 01/20/2015, while touring inpatient Medical and Surgical Units and the Intensive Care Unit, it was observed:</p> <p>a. At 1430 hours, patient rooms #411, #412 and #303, that had been cleaned by housekeeping and were ready for admissions, had dust and debris in the patient bedside tables drawers. Room #412 had debris on the over-the-bed patient table.</p> <p>b. At 1445 hours, it was observed that the pantry refrigerator on the surgical unit had spilled food and sticky debris on the</p>	S000596	<p>1. The deficiency has been corrected by the Manager of the EVS department. The Manager conducted education with all EVS on terminal cleaning policy and process of a patient room. Education was conducted one on one with staff members.</p> <p>2. New hire orientation list has training on terminal cleaning policy and process.</p> <p>3. The EVS Manager is responsible for the above.</p> <p>4. EVS Manager will submit to Infection Control, quality control indicator monthly on terminal cleaning inspections and these will be reported to the Infection Control Committee.</p>	02/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S001014	<p>lower shelves.</p> <p>c. At 1545 hours, the clean supply room on the surgical unit had wrappers and dust/debris on the floor.</p> <p>3. Staff member #A3, the Chief Nursing Officer, indicated that it is Housekeeping's responsibility to clean rooms thoroughly and nursing and dietary responsibility to keep refrigerators clean. Staff #A3 concurred with the observations.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on document review, observation and interview, the facility failed to</p>	S001014	1. All Stat accucheck glucose controls were examined and any	02/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>implement its policy and follow manufacturer recommendations for glucometer testing solutions and patient test strip containers in one instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Facility Stat Strip Training document, reviewed on 12/17/2013, stated "The expiration date for using the test strips and solutions is 90 days from the date the packaging is opened." 2. The package insert which stated manufacturer's recommendations for Nova Stat Glucose Control Solution and Test Strips indicated "Use only for three months after first opening. When you open a new vial of control solution or test strips, count forward 3 months and write that date on the vials. Discard the remaining solution or test strips after the date you have written on the vials". 3. While touring the Obstetrics Unit on 1/20/2015 at 1300 hours, it was observed that glucometer testing solutions and patient test strip containers were not dated with the expiration date 3 months following opening. 4. On 1/20/2015 at 1300 hours, staff member # A3 indicated that he/she concurred with these findings. 		<p>unlabeled ones were discarded.</p> <ol style="list-style-type: none"> 2. The current policy was reviewed and revised regarding "Nova Stat Strip Glucose Meter". Staff was educated on the Glucose control Solutions must be dated with the 90 day expiration date. 3. The CQO is responsible for the above items. 4. The CQO will conduct ongoing monitoring monthly to monitor compliance with dating of glucose control solution vials. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S001197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the safety program failed to ensure that periodic fire inspections were conducted at the facility.</p> <p>Findings:</p> <p>1. On 1-20-15 at 1045 hours, director of quality A4 and safety officer A16 were requested to provide documentation of a recent State and/or local fire inspections and none was provided prior to exit.</p> <p>2. During an interview on 1-20-15 at 1320 hours, the director of engineering A27 confirmed that the most recent fire inspection was conducted in September</p>	S001197	<p>1. The Deficiency has been corrected by the Plant Operations Director. The Fire Marshall was contacted and a hospital wide fire inspection was scheduled and completed.</p> <p>2. Plant Operations Director is responsible for contacting the Fire Marshall annually to schedule annual inspection prior to the 18 month deadline.</p> <p>3. The Fire Marshall Inspection has been added to annual Environment of Care Calendar with a due date annually in February.</p> <p>4. Annual Fire Marshall Inspection has been added to the standing Environment of Care Agenda as an annual report.</p>	01/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	2012. Staff A27 confirmed that the facility lacked documentation of a fire inspection in 2013 or 2014 and confirmed that no documentation requesting an inspection from fire officials was available for review.				