STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	150069		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005063 Survey Date: 07/13-15/15 QA: cjl 08/03/15	S 0000	Please see responses/attachments Thank you	
S 0102 Bldg. 00	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on observation and interview, the hospital failed to follow Indiana Code IC-19-5-14 which is to inform obstetrics patients and fathers of the Putative Fathers registry. Findings: 1. IC-19-5-14 states **Public Notice and purpose and operation of registry** Sec. 14 (a) Each:	S 0102	*Response* The Notice to Putative Fathers sign was placed on the Mother Baby Services Unit on August 10, 2015 by the Nursing Director of Mother Baby Services. Attachment- A	08/10/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	(3) **hospital shall post in a conspicuous place** a notice that informs the public about the purpose and operation of the registry. (b) The notice under subsection (a) must include information regarding the following: (1) Where to obtain a registration form. (2) Where to register. (3) The circumstances under which a putative father is required to register. (4) When under section 12 of this chapter a putative father is required to register. (5) The consequences of not submitting a timely registration. 2. While touring the obstetrics area of the hospital, including waiting areas and all entrances, on 7/14/2015 at 1430 hours, it was noted that there was no evidence of putative father sign in any area. 2. In interview on 7/14/2015 at 1445 hours, staff member #A2 indicated that the facility did not have putative father information posted, and that the staff verbally informs fathers if an issue comes up.			
S 0554	410 IAC 15-1.5-2 INFECTION CONTROL			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
Bldg. 00	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, document review and interview, the facility created 6 conditions (basement women's locker room, basement men's locker room, ambulance garage, medical surgical unit, emergency department, intensive care unit) which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors. Findings: 1. On 7-13-2015 at 12:50 pm, in the presence of employee #A3, Director Facility Operations, it was observed in the basement women's locker room, there was a considerable amount of dust on the top of the lockers. 2. On 7-13-2015 at 1:00 pm, in the presence of employee #A3, it was observed in the basement men's locker room there was considerable amount of dust on the top of the lockers. 3. On 7-14-2015 at 10:20 am, in the presence of employee #A3, it was	S 0554	*Response* Findings 1 & 2: Men's and women's locker rooms were dusted on 7/14/15. Environmental Services (EVS) Supervisor made staff aware that this is part of weekly assigned duties and will do random checks for 3 months to ensure compliance. Finding 3: Paper products were placed into plastic bags / containers on 7/12/15. Emergency Medical Services (EMS) Director educated staff regarding the potential infection risk of paper products being exposed in the store room. The EMS Director will do random checks for 3 months to ensure compliance. Finding 4, 5 (a-c), & 6: Glucometer bases were cleaned 7/14/15. Staff educated on policy for cleaning bases by the Infection Preventionist on	08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015
NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 EAST SR 62 MADISON, IN 47250	

(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
	observed on a shelf in a storage/work area in the ambulance garage, there were 7 packages of handtowels, the ends partially exposed, and 4 large rolls of handtowels, the entire rolls exposed. It was also observed the area was used as a work area and there was dirt and debris in it. 4. Policy Ancillary Blood Glucose Meter Maintenance, last reviewed 02/05/2014, indicated that the glucometers are to be cleaned after each use, and the bases are to be cleaned when soiled. II. Cleaning the base unit A. Unplug the base unit. B. Wipe the surfaces with a soft cloth slightly dampened or 70% isopropyl alcohol... C. Dry thoroughly after cleaning. Visually verify that no solution is seen in the connector at the completion of the cleaning. D. Plug in the base unit. 5. While touring the hospital units, it was observed: a. On 7/13/2015 at 1225 hours, on the fourth floor Medical Surgical Unit, the base of the unit's blood glucose monitor was dusty and had small specks of dark debris in the base.		8/11/15. Nursing Directors / ED Charge Nurse will do random checks for 3 months to ensure compliance. Infection Preventionist will add to environmental services rounding to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	b. On 7/14/2015 at 1135 hours, during a tour of the Emergency Department, the base of the blood glucose monitor was dusty and had dark smudges on it. c. On 7/14/2015 at 1320 hours, during a tour of the Intensive Care Unit, the base of the unit's blood glucose monitor had dust in the base. 6. In interview on 7/15/2015 at 1100 hours, staff member #A7, Infection Control Officer, indicated that the cleanliness of the bases of blood glucose monitors needed to be addressed.			
S 0708 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (b)(1)(2) (b) The organization of the medical record service shall be appropriate to the scope and complexity of the services provided, as follows: (1) The service shall be directed by a registered health information administrator (RHIA) or a registered health information technician (RHIT). If a full time or part time RHIA or RHIT is not employed, then a consultant RHIA or RHIT shall be provided to assist the person in charge. Documentation of the findings and recommendations of the consultant shall be maintained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	(2) The medical record service shall be provided with the necessary direction, staffing, and facilities to perform all required functions in order to ensure prompt completion, filing, and retrieval of records. Based on document review and interview, the hospital failed to document the findings and recommendations of a medical records consultant in 1 instance. Findings: 1. Review of a document entitled KDH Interim Medical Records Plan - April 2015, from employee #A6, Vice President Finance, indicated employee #A7, an employee who was not a RHIA (registered health information administrator), or an RHIT (registered health information technician), will provide [medical record department] oversight with consultation when needed from employee #A8, an RHIA. 2. In interview, on 7-14-2015 at 3:10 pm, employee #A1, Chief Executive Officer, confirmed the above. 3. At the above date and time, employee #A1 was requested to provide documentation of any findings and recommendations of employee #A8 since April 2015. 4. At the above date and time, employee #A1 indicated there was no documentation as requested and no other documentation was provided prior to exit.	S 0708	*Response* Consultation between the RHIA consultant and Interim Health Information Management Services (HIMS) Director took place on 8/7/15. Statistics and reports normally reported to Medical Staff Quality Committee (MSQC) were reviewed and discussed. Findings were recorded (attached) and followed prior to the submission of data for MSQC on 8/10/15. These findings will be maintained by the RHIA consultant and in the office of the Interim HIMS Director. The Interim HIMS Director will schedule and ensure documentation of quarterly meetings with the RHIA consultant until an RHIA or RHIT Director is hired for HIMS. Attachment- B	08/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on document review and staff interview, the hospital failed to complete all documentation for evidence of informed consent using procedures and treatments for which it is required as specified by the informed consent policy by the medical staff and governing board, and consistent with federal and state law for two (Patient #1, Patient #4) of ten patients receiving blood. Findings included: 1. The Blood/Blood Products Administration policy, reviewed 3/11, read: "...obtain patient signature on Consent for Transfusion of Blood or Blood Products."	S 0754	*Response* Laboratory Manager and Nursing Directors reeducated staff that all consents are to be completed appropriately and that Lab will initiate review of the consent prior to releasing a unit of blood / blood product. Nursing Directors will do random checks of blood consents on patient charts for the next 3 months to ensure compliance. Laboratory Manager will ensure current QA process includes the informed consents.	08/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	2. Two patients had incomplete consent forms prior to receiving four units of blood/blood products. a. Patient #1 received Unit #1 on ____ at _____ and Unit #2 on ____ at _____. The consent form was missing its signature date. b. Patient #4 received Unit #7 on 6/02/15 1715 and Unit #8 on 7/02/15 at 1457. The consent form was missing its witness signature. 3. On 7/13/15 at 1:45 p.m., staff member #A5, administrative laboratory director, conferred that the above-listed patients had received blood administration without benefit of completed consent forms.			
S 1020 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	are stored and which address, but are not limited to, the following: (A) Separation of drugs designed for external use from drugs intended for internal use. Based on document review, the hospital failed to ensure the monthly inspection of 1 area (ambulance area) where drugs are stored. Findings: 1. On 7-15-2015 at 1:30 pm, employee #A4, Nurse Informatacist, was requested to provide documentation of monthly pharmacy review of medication reports from the ambulance area for the months of March, April, and May, 2015. 2. Review of documents of monthly medication reports for that area indicated there was no documentation they had been reviewed by pharmacy personnel. 3. In interview, on 7-15-2015 at 3:00 pm, employee #A4, Nurse Informatacist, confirmed all the above.	S 1020	*Response* Processes have been revised so that the medication reports for EMS are reviewed monthly by a Pharmacist. Director of EMS and Director of Pharmacy will ensure compliance with the revised process by completing random audits and report findings as department QA through December 2015. AttachmentC	08/01/2015
S 1024 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	150069		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation and document review, the hospital failed to store outdated drugs in a separate area from general inventory in 1 instance (pharmacy). Findings: 1. On 7-13-2015 at 3:45 pm, in the presence of employee #A3, Director Plant Operations, it was observed in a refrigerator in the pharmacy, there were 27 ampoules of Octreotide Acetate Injection, 100 mcg/1ml, each having an expiration date of 5-2015. 2. On the above date and time, #A3 confirmed the outdated products.	S 1024	*Response* Outdated medication was removed from inventory and placed in the expired medication bin by the Director of Pharmacy on July 13, 2015. In review of the former process it was noted that the log only listed one refrigerator while in fact there are 2 located in the Pharmacy. Staff was reeducated by the Director and log revised to ensure staff completes inventory review of both refrigerators. Director of Pharmacy will do random checks for the next 3 months to ensure compliance.	07/17/2015
S 1118 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, one of ten kitchen workroom sections contained a potential hazardous condition to the kitchen's staff. Findings included: On 7/13/15 at 11:45 a.m., the surveyor observed one 3 foot unchained gas cylinder, used for soda dispensing, capable of falling over in the beverage storage room.	S 1118	*Response* The unchained CO2 cylinder was immediately secured to the wall by the Director of Nutrition Services on July 13, 2015. Nutrition Services supervisors were educated to confirm that CO2 cylinders are secured when delivered. In addition, checking the CO2 cylinders was added to the monthly sanitation walk through "Statement of Fact" report and, the Director of Nutrition Services will do random checks for the next three months to ensure compliance.	08/11/2015
S 1150 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9) (c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	150069		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department. Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 2 instances. Findings: 1. On 7-13-2015 at 12:55 pm in the presence of employee #A3, Director Facility Operations, it was observed in the shower of the basement men's locker room, there was a flexible hose connected to a water spigot without a backflow prevention device. 2. On 7-13-2015 at 12:55 pm in the presence of employee #A3, it was observed in the shower of Sleep Lab Room 1, there was a flexible hose connected to a water spigot without a backflow prevention device.	S 1150	*Response* Senior Director of Facility Operations received from the company the verification that the flexible hose connected to water spigot has the required backflow prevention device as part of handle. AttachmentD	07/31/2015
S 1160 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	(d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on document review, observation, and interview, the hospital failed to regularly maintain 1 piece of patient care equipment in accordance with the manufacturer's recommendations. Findings: 1. Review of a document entitled MAINTENANCE Routine Procedures for the Zoll R Series defibrillator, indicated a fully charged spare battery pack accompanies the unit. 2. On 7-13-2015 at 2:50 pm in the presence of employee #A3, Director Facility Operations, it was observed there was a Zoll R Series defibrillator on a cart in the hall of the Radiation/Oncology hallway. At that same time and date, it was observed there was no spare battery pack on the cart. 3. In interview, on the above-stated date and time, a radiology staff member, indicated there was no spare battery on the cart or in the area.	S 1160	*Response* Current processes and close proximity to the Emergency Department facilitates prompt intervention and treatment for any patient experiencing an emergency. Therefore, the Oncology Director will remove the Zoll R series defibrillator after staff and physicians have been inserviced on the change in process. In addition, an emergency reaction kit for IV contrast will be placed in the CT area. This will institute the same process as currently utilized in our Medical Imaging department.	08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
S 1164 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 4 pieces (sleep study machine, patient scale, arterial segmental press machine and a stress machine) of equipment. Findings: 1. On 7-13-2015 at 11:55 am, employee #A3, Director Facility Operations, was requested to provide documentation of PM on a sleep study machine. 2. Review of a document entitled Maintenance for a sleep study machine indicated safety checks should be performed periodically and no less than twice a year.	S 1164	*Response* Manufacturer's recommended preventative maintenance has been completed for each piece of equipment noted in the deficiency and will continue in the future according to the manufacturer's recommendation (annually or at least twice a year). The Senior Director of Facility Operations has added the required PMs to the electronic system which will automatically generate PM work order when due.	08/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	3. In interview on 7-15-2015 at 10:55 am, employee #A3 indicated there was no documentation as requested and no other documentation was provided by exit. 4. On 7-13-2015 at 1:35 pm, employee #A3, was requested to provide documentation of PM on a Detecto patient scale in the Cardiopulmonary area. No documentation was provided. 5. On 7-13-2015 at 1:45 pm, employee #A3, was requested to provide documentation of PM on an Arterial Segmental Press machine and a Stress machine, both located in the Stress Room. The only documentation provided for each piece was an electrical inspection.			
S 1168 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review, the facility failed to follow the manufacturer's recommendation for daily testing of 1 of 1 defibrillator. Findings: 1. Review of the manufacturer's manual for a Zoll M Series defibrillator indicated the defibrillator was recommended to be checked once per day. 2. Review of documents entitled EMERGENCY CHECKLIST, UNIT Onc, dated March, April, May, and June, all for year 2015, indicated there were 13 out of 122 days, 10.6 %, the defibrillator checks were not done.	S 1168	*Response* A log will no longer be required as the Oncology Director will remove the Zoll R series defibrillator after staff and physicians have been inserviced on the change in process (see S 1160 for additional information).	08/14/2015
S 1186 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (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: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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
	management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on document review and interview, the facility failed to conduct fire drills in accordance with NFPA (National Fire Protection Association) Life Safety Codes, and facility procedure in 8 of 20 instances. Findings: 1. Review of NFPA 101 Life Safety Code, 2000 Edition, indicated fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 2. Review of a document entitled FIRE DRILL Procedure, reviewed/revised 2/13, indicated drills shall be conducted quarterly on each shift. 3. In interview, on 7-15-2015 at 11:35 am, employee #A3, Director of Facility Operations, indicated there were 3 shifts at the hospital and one each at 2 offsites.	S 1186	*Response* Senior Facilities Director has revised the process to ensure that fire drills will take place once per shift per quarter at the Hospital Main Campus, once per quarter at offsite locations (Hilltop Rehab and Versailles Rehab facility) The policy has been revised and is attached) Compliance will be monitored monthly and reported quarterly to the Safety Committee.	08/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015
NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 EAST SR 62 MADISON, IN 47250	

(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
	4. Review of fire drills conducted at the hospital for calendar year 2014 indicated there were no fire drills conducted for the second quarter 2nd shift, and third quarter 1st shift. 5. Review of fire drills conducted at the Hilltop offsite for calendar year 2014 indicated there were no fire drills conducted for the first, second and fourth quarters for the 1st shift. 6. Review of fire drills conducted at the Versailles offsite for calendar year 2014 indicated there were no fire drills conducted for the first, third and fourth quarters for the 1st shift. 7. In interview, at the above date and time, employee #A3 confirmed all the above and no further documentation was provided prior to exit.			