

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  04/23/2014
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NAME OF PROVIDER OR SUPPLIER  KING'S DAUGHTERS' HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1373 EAST SR 62 MADISON, IN 47250
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 4/21/2014 through 4/23/2014</p> <p>Facility Number: 005063</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: claughlin 04/29/14</p>	S000000	Please find our Plan of Correction(s) as listed by the appropriate ID prefix tag (tag number). Also, please find the attached documents. Thank you.	
S000726	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of</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>service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on documentation review, observation and staff interview, the facility failed to ensure patient medical information could not be accessed by unauthorized personnel for King's Daughters' Cancer Treatment Center.</p> <p>Findings included:</p> <p>1. King's Daughters' Health Data Integrity (last approved 1/17/2014) indicated auxiliary personnel shall be restricted to easy access of patient data and information. Patient data and information will be secured at all times.</p>	S000726	All Cancer Treatment Center medical records/patient information will be secured and not accessible to unauthorized personnel. On 4/22/2014 patient records were noted to not be secure by ISDH. These violations are noted in s726. Access to patient medical records/patient information by FMS (housekeeping service vendor for KDH) after hours required the following actions: · Patient information noted in front area surrounded by three walls without a door no longer contains patient information after hours. This filing system (desk trays) is no longer used for paper records and was moved into the locked chart room directly adjoining this area on 4/22/14. All radiation oncology patient information is stored in the locked chart room each evening	06/06/2014			

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S001118	<p>2. At 11:15 AM on 4/22/2014, King's Daughters' Cancer Treatment Center was toured. Storage of patient films was observed in a storage area with walls around three sides of the storage shelves. However, the front of the storage area did not have a wall securing the patient medical data. One office was observed with patient health information on desk trays and not in a secured location.</p> <p>3. At 11:25 AM on 4/22/2014, staff member #22 indicated the contracted housekeeping company cleans the cancer center after hours. The patient films are not locked up before the staff leaves for the day; therefore, the patient films are left unsecured when the housekeepers clean all the offices and exam rooms.</p>		<p>as the cancer center is closed. · Port films noted to be accessible to unauthorized staff after hours will be secured by a door that will be installed. The door was ordered May 21, 2014 and will be installed within the next 3 weeks. · For security purposes, locks in the cancer center to areas containing patient information are being replaced. This will be completed by June 6, 2014. Staff education concerning HIPAA and medical record security was completed with cancer center staff immediately on 4/22/14 verbally by Jessica Kietzman, Cancer Center Director. Medical record security and plan noted above was verbally communicated to staff 1:1 on 5/21/14 and 5/22/14. Written correspondence was also communicated via email to all cancer center staff on 5/22/14. A daily log will be completed by Cancer Center staff to verify that records are secured daily (M-F) prior to leaving the building. Jessica Kietzman will be responsible for monitoring the cancer center compliance with securing medical records as noted above. This log will begin once the above actions have been completed. Compliance will be reported to Quality Committee and Cancer Committee quarterly. Caryl Liptak, Privacy Officer will also randomly audit compliance.</p>				

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	<p>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 documentation review and observation, 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 were assured in four (4) instances.</p> <p>Findings included:</p> <p>1. King's Daughters' Health Compressed Gas Safety policy (last reviewed 2/23/2013) stated, "Chains, special boxes or other methods of securing the cylinders in a positive manner shall be used at all times."</p>	S001118	Per KDH policy "All compressed gases shall be stored in chains, special boxes, or other methods of securing the cylinders in a positive manner shall be used at all times". The day the licensure survey was performed two "E" canisters were observed in the upright position and unsecured. This condition was corrected immediately following discovery, (April 23, 2014). To ensure that the storage of compressed gases remains in compliance, all locations where compressed gases are stored will be inspected by the Security Officer on duty on a daily basis. Any deficiencies will be reported to the Director of Facility Operations for immediate correction. Compliance will be reported to the Quality Committee and Safety Committee quarterly. Plant Operations staff will go through a mandatory training session on June 5, 2014 on the proper storage of compressed gases. An eye wash station was	06/11/2014			

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	<p>2. At 1:00 PM on 4/22/2014, the Med Gas Storage Room was toured. Two "E" canisters that contained Nitrous Oxide and Carbon Dioxide were observed stored in an upright position unsecured by chain or another effective method.</p> <p>3. King's Daughters' Health Environment of Care policy #SA.8 (last reviewed 2/23/2014) stated, "An eye wash station is to be provided close to the battery charging station."</p> <p>4. At 1:20 PM on 4/22/2014, the EVS (environmental services) Equipment room was inspected. The room was observed charging two battery operated floor scrubbers. The 12-volt batteries were observed exposed during the charging process. The room was observed without an eye-wash station for immediate use if acid would come in contact with a person's eyes.</p>		<p>installed in the EVS Equipment room on May 14, 2014, refer to attached picture. A wall mounted bottle eye wash station has been ordered and will be installed in the EVS Equipment room (battery charging area) no later than June 2, 2014. Ryan Geib, Director of Facility Operations will be responsible for ensuring completion. The EVS Supervisor will be responsible for performing a monthly inspection on the eye wash station and the documentation thereof. The Delta Bench Grinder was observed with the shields in the upright positions which is an unsafe position. The deficiency was corrected immediately upon discovery (April 23, 2014). The staff members using the bench grinder were notified verbally by Ryan Geib, Director of Facility Operations that the shields were to be kept facing down with no more than 1/8" clearance. A sign was placed on the bench grinder on May 29, 2014 that states "Shields are to remain in the down position" as a visual reminder to all staff. To reiterate safe work practices to all Plant Operations staff, a weekly tool box talk will begin on June 2, 2014 and will be conducted by the Facility Operations Manager or Director of Facility Operations. A log will be kept of the attendees and the subject matter discussed. The EVS storage rooms were observed to be cluttered with</p>				

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	<p>5. King's Daughters' Health Environment of Care Safety Management Plan (last reviewed 2/23/2014) indicated the physical environment shall be free of hazards and manage staff activities to reduce the risk of injuries. The physical environment shall be maintained in clean and organized fashion to protect staff, patients, and guests from possible injuries. The plan also noted the hospital to adhere to OSHA and Life Safety Code standards.</p> <p>6. Current OSHA standards require bench mounted abrasive wheels used for external grinding shall be provided with safety guards. Safety guards shall be strong enough to withstand the effect of a bursting wheel. Workrests shall be kept adjusted closely to the wheel with a maximum opening of 1/8" to prevent the work from being jammed between the wheel and the rest, which may cause wheel breakage.</p>		<p>various chemicals, supplies and equipment. The storage room will be organized using wire shelving and wall hooks by June 11, 2014. Ryan Geib, Director of Facility Operations will be responsible for ensuring this items completion. Work has been ongoing to get these rooms organized. To prevent this from occurring again, the EVS storage rooms will be inspected during the weekly Life Safety inspections for general organization. Compliance will be reported to the Quality Committee and the Life Safety Subcommittee quarterly.</p>		

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	<p>7. At 12:30 PM on 4/22/2014, the Maintenance Department was toured. A Delta bench mounted grinder/sander was observed with both eye protection guards 180 degrees upward. The right bench workrest for the abrasive wheel was slanting downward. Both observations would not provide safe conditions for the operator.</p> <p>8. At 1:30 PM on 4/22/2014, two EVS storage rooms were inspected. Both rooms were observed cluttered and disorganized with assorted chemicals, supplies, boxes, etc.</p> <p>9. At 1:45 PM on 4/22/2014, staff member #12 confirmed the Environmental Service's storage rooms were disorganized. The staff member confirmed the bench grinder workrest and eye guard were not in the correct position for safe operation.</p>						

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S001124	<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 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><b>Based upon review of centrifuge policies and procedures, preventative centrifuge maintenance (PM) records, patient records, and staff interview, the laboratory failed to document required rotations</b></p>	S001124	<p>Proper centrifugation of specimens to obtain cell free serum or plasma is critical to the accuracy and precision of laboratory tests. On 04/22/14 improper centrifugation was noted on the following patients. These violations were stated in S1124. 03/11/14 patient #11 has been reported as 31 mg/dL for protein. Scientific Instrument inspection</p>	04/24/2014			

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	<p><b>per minute (rpm) testing and timer checks for two of seven centrifuges used for patient testing by the staff.</b></p> <p><b>Findings include:</b></p> <p><b>1. On 4/22/14 between 10:00 p.m. and 11:45 a.m., review of the policy, "Specimen Processing by Centrifugation", revised 6/13/11, read:</b></p> <p><b>"The following procedures must be used when processing specimens by centrifugation to insure that the serum or plasma tested is of adequate quality.</b></p> <table border="1"> <tr> <td>Area</td> <td>Test</td> <td>Specimen</td> </tr> <tr> <td>Centrifuge</td> <td>RPM</td> <td>Time</td> </tr> <tr> <td>Hematology</td> <td>SF</td> <td>Spinal fluid</td> </tr> <tr> <td>Statspin</td> <td>2200</td> <td>2 minutes</td> </tr> <tr> <td>Microbiology</td> <td>SF</td> <td>Spinal fluid</td> </tr> <tr> <td>Spinchron</td> <td>3500</td> <td>10 minutes</td> </tr> </table> <p><b>Legend:</b></p> <p><b>SF: spinal fluid</b></p> <p><b>2. In observation on 4/22/14 between 10:00 p.m. and 11:45</b></p>	Area	Test	Specimen	Centrifuge	RPM	Time	Hematology	SF	Spinal fluid	Statspin	2200	2 minutes	Microbiology	SF	Spinal fluid	Spinchron	3500	10 minutes		<p>checked at 1300 RPM and not 2200 RMP for Spinal Fluid Differential testing. 03/05/14 patient #12 has been reported as NOS (no organism seen). The specimen had been spun in the ROTOFIX at 2000. Scientific Instrument inspection checked at 3000 RPM and not 2000 RMP per policy for Spinal Fluid culture testing. The following procedures must be used when processing specimens by centrifugation to insure that the serum or plasma tested is of adequate quality.</p> <p>HEMATOLOGY TEST SPEC CENTRIFUGE RPM TIME SYNOV FL DIFF SYNOV FL STATSPIN CYTOFUGE 1300 2M SP FLUID DIFF SPINAL FL STATSPIN CYTOFUGE 2200 2M MISC BODY FL DIFF MISC FL STATSPIN CYTOFUGE 1300 2M MICROBIOLOGY TEST SPEC CENTRIFUGE RPM +/-200 TIME M=MINUTES SP FLUID, GRAM ST SP FL PPREVO COLOR 1500 5 M SP FLUID, CULTURE SP FL ROTOFIX 2000 10 M SPUTUM, TB CULT SPUTUM ROTOFIX 3000 10 M</p> <p><b>Corrective Action On 04/24/14</b> Scientific instruments conducted the proper inspection on the following centrifuges: Scientific Instrument performed RPM check on STATspin at 2200 RPMs for 2 minutes. Report attached. Scientific Instruments performed</p>	
Area	Test	Specimen																				
Centrifuge	RPM	Time																				
Hematology	SF	Spinal fluid																				
Statspin	2200	2 minutes																				
Microbiology	SF	Spinal fluid																				
Spinchron	3500	10 minutes																				

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	<p><b>a.m., it was noted:</b></p> <p><b>1. The Biomed inspection sticker on centrifuge #1 (Statspin) used for spinal fluid checks in hematology read, "1300 rpm, 2/21/14" in lieu of 2200 rpm and no timer check sticker (required timer 2 minutes) was observed.</b></p> <p><b>2. Review of the centrifuge #2 (Spinchron), used in microbiology for spinal fluid cultures had no Biomed rpm (required 3500 rpm) or timer sticker checks (required 10 minutes).</b></p> <p><b>3. On 4/22/14 between 10:00 p.m. and 11:45 a.m., two patients had been reported including:</b></p> <p><b>a. Patient #11 had been reported on 3/11/14 (31 milligrams/deciliter (mg/dl) for protein) for spinal fluid hematology testing. The specimen had been spun in the Statspin (centrifuge #1) at 1300 rpm in lieu of at 2200 rpm with a 2 minutes spin (no timer check</b></p>		<p>RPM checks on ROTOFIX at 2000 RPMs for 10 minutes. Report attached. <b>Follow Up</b> RPM checks and maintenance are performed annually for all centrifuges with an additional bi-annual check for the serologic centrifuges. Timers and the speed of the centrifuge must be confirmed. All centrifuges have lid portals that allow photoelectric monitoring of RPMs without disabling the safety features of the centrifuge. <b>Centrifuge checks are performed by Scientific Instrument Center, Inc. All checks are performed in annually and monitored by the Administrative Laboratory Director and Medical Laboratory Directory.</b></p>		

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S001162	<p><b>noted).</b></p> <p><b>b. Patient #12 had been reported on 3/05/14 (no organisms seen (NOS) for culture) for spinal fluid microbiology testing. The specimen had been spun in the Statspin (centrifuge #2); however, there was no documentation for either 3500 rpm or 10 minute timer checks.</b></p> <p><b>4. On 4/22/14 at 11:45 a.m., staff member #6 acknowledged that neither centrifuge #'s 1 or 2 had been checked for required rpm or timer requirements prior to reporting patient results.</b></p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:  (A) All mechanical equipment (pneumatic, electric, or other) shall</p>			
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	<p>be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review, the facility failed to comply with manufacturer recommended hot pack temperature for the hydrocollator located in the Rehabilitation Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The Operation Manual instructions for the use and operation for Rehabilitation Department's hydrocollator M-2 Master Heating Unit noted the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the steam packs.</li> <li>The Rehabilitation Department hydrocollator M-2 Master Heating</li> </ol>	S001162	<p>There is a process in place per Policy and Procedure Guidelines. Policy revision includes the reminder to report to maintenance any temperature out of range. Both policies that address this are attached. The monitoring record is also attached, which is checked daily before use and shows a written reminder to call maintenance. The staff has been educated on the policies to report any "out of range temperatures" to maintenance on 4/24/14. We have reviewed the monitoring record with all staff as well on 4/24/14. We will follow all policy and procedures in the KDH Rehabilitation Policy and Procedure Manuel section 5, Equipment Maintenance and Infection Control Equipment Care. The Director of Rehabilitation Services will enforce policy and procedures and review periodically. Compliance will be reported to the Quality Committee quarterly. Correction completed 4/24/14</p>	04/24/2014

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S001164	<p>Unit April 2014 temperature log revealed the water was less than 160 degrees Fahrenheit for 15 (04/01-09/14, 04/14/14, 04/16/14, 04/18-21/14) of 21 days.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:  (B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on documentation review and staff interview, the facility failed to conduct routine preventive maintenance on 8 syringe infusion pumps.</p> <p>Findings included:</p> <p>1. Medfusion Syringe Infusion Pump service manual recommends</p>	S001164	The Medfusion Syringe pumps were observed to not have a preventative maintenance schedule in place nor have had any maintenance inspections performed. Four of the eight syringe pumps will be sent to AIV on June 3, 2014 for calibration and preventative maintenance. The time expected to inspect these four (4) pumps and return to KDH in 16 days provided their is no parts requiring replacement. The first four (4) pumps will be compliant by July 1,	08/01/2014	

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  04/23/2014
NAME OF PROVIDER OR SUPPLIER  KING'S DAUGHTERS' HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1373 EAST SR 62 MADISON, IN 47250		
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	<p>that routine maintenance procedures be performed at least once every six months.</p> <p>2. Equipment Work Order Summary for the eight syringe infusion pumps noted the health care equipment had never had a preventive maintenance performed on them. The Equipment summary noted three pumps were purchased on 4/16/2013 and the other five were purchased prior to 2013.</p> <p>3. At 10:30 AM on 4/22/2014, staff member #14 indicated the eight hospital infusion pumps were not added to the Preventive Maintenance schedule. Therefore, the eight perfusion pumps never had a routine preventive maintenance performed on them.</p>		<p>2014. Following return of the first four (4) pumps by AIV, the second set of four (4) pumps will be sent to AIV for calibration and preventative maintenance. Expected compliance date for the second set of pumps is August 1, 2014. Medfusion's required inspection is bi-annually. Following the established inspection date of each set of pumps, the Director of Facility Operations will be responsible for establishing a preventative maintenance schedule for each pump which shall occur at six (6) month intervals. The Biomedical department will be responsible for conducting the inspection and placing the Biomed Inspection decal on the pump once inspected.</p>		