

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 11/03/2011
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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, IN46320
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 008899</p> <p>Survey Date: 11/1-2-3/2011</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/28/11</p>	S0000		
S0284	<p>410 IAC 15-1.4-1 (b)(3)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules and that the bylaws and rules are reviewed and approved at least triennially. Governing board approval of medical staff bylaws and rules shall not be unreasonably withheld.</p> <p>Based on policy review and interview, the governing board failed to to ensure that</p>	S0284	S 284 Immediate Corrective Action: Documentation was	12/03/2011

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>the medical staff reviewed and revised facility policies at least triennially in fourteen (14) of twenty-three (23) facility policies reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Policies and Procedures Development and Revision", last reviewed/revised in 11/2009 states in pertinent part on page 1, "All P/P will be reviewed a minmum of every three years to determine whether changes or additions to existing P/P are required". 2. Document review revealed the following policies in which the dates indicated the policy had not been reviewed/revised in excess of three (3) years: <ol style="list-style-type: none"> a. "Nursing Staffing" was last reviewed/revised 08/12/2003. b. "Restraints and Seclusion" was last reviewed/revised 1/13/2007. c. "Care of the Patient After Death" was last reviewed/revised 11/14/2006. d. "Skin Care, Assessment and Maintainence Of" was last reviewed/revised 07/16/2008. e. Infection Control Manual Policies were all last reviewed/revised on 9/19/2007, which included: <ol style="list-style-type: none"> i. "General Sanitation" ii. "Routine Daily Cleaning and 		<p>located noting the policies were approved by the MEC, Quality Council and Governing Board on April 22, 2009. As noted during the survey, this hospital has had a change in operations ownership in 2011. The documentation of review was stored and thus not available during the survey. It has been replaced on the manuals currently in use. Further Corrective Action to prevent Recurrence: The CCO and leadership team developed a list of 31 core policies for immediate implementation to eliminate any confusion with old policies. A schedule is in place with assignment to various team members for conducting the in-services and documenting which have been completed. These will be fully in place by December 31, 2011; any conflicting policies will be removed as these are implemented and archived. The Quality Council designated a task group to oversee the implementation of the policy transitions. The task group developed a work plan to complete a transition to Kindred policies (including any relevant committee review and approval) by February 28, 2012. The agendas of all major committees (MEC, QC and GB) were reviewed to ensure that there is a standing agenda item for policy review to ensure that all are timely reviewed within the three</p>	

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	<p>Disinfection"</p> <p>iii. "Cleaning Patient Room After Discharge"</p> <p>iv. "Linen"</p> <p>v. "Medical Waste"</p> <p>vi. "Nutrition Room"</p> <p>vii. "Environmental Rounds"</p> <p>viii. "Equipment Cleaning"</p> <p>ix. "Common Area Cleaning"</p> <p>x. "Employee Screening: New Hire and Ongoing"</p> <p>3. During interview with S1 on 11-3-2011 at 1:45 PM, S1 verified that:</p> <p>a. the most current version of policies had been requested.</p> <p>b. the above-presented policies were overdue for review/revision according to facility policy.</p>		<p>year period. Monitoring: A status report will be presented to the Quality Council monthly until the entire policy transition is completed. Once it is finished, the standing items for policy review will remain and be reviewed according to the master schedule. Responsible Role: Chief Clinical Officer</p>		

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S0362	<p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths. Thus the facility failed to notify procurement organization of potential organ donors.</p>	S0362	S362 Immediate Corrective Action: Upon receipt of the verbal exit findings (November 3), the facility implemented a Mortality Log to capture all deaths with the associated dates and time of notification to the organ and tissue donation agency. The	12/03/2011	

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the contract between the hospital and the Gift of Hope Organ & Tissue Donor Network, indicated the hospital shall provide "All notification of death or imminent death...". 2. Review of the documentation presented failed to show all deaths were reported. Organ Donation Program Report for 2011 indicated 8 deaths occurred in January 2011 and only 6 deaths were reported; 5 deaths were reported in February 2011 and only 4 were reported; 5 deaths occurred in March and 6 were reported; 4 deaths occurred in April and only 3 were reported; 8 deaths occurred in May and 9 were reported; 10 deaths occurred in September and only 8 were reported; 10 deaths occurred in October and only 8 were reported. 3. Interview with Employee #A3 on November 3, 2011 at 1:00pm verified the above data. 		<p>nurse manager or her designee will collect, monitor, reconcile all deaths and maintain this log. To date, all deaths have been reported. Further Corrective Action to prevent Recurrence/Monitoring: The nurse manager and all nursing supervisors were in-serviced on the organ donation reporting requirements. The morning flash meeting agenda was amended to ensure that death reporting requirements are monitored each death. The status of implementation of the Mortality Log will be reported monthly at the Quality Council x 3 under POC status to ensure that all requirements are met. Responsible Role: Chief Clinical Officer</p>		

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S0556	<p>410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on policy review, personnel file review, and interview, the facility failed to ensure the infection control plan was effective in relation to the documentation of time given and time read for TB skin tests; self-reported Varicella immunity, and negative or equivocal titres lacking follow-up, for five (5) of twelve (12) employee files reviewed (P2, P3, P4, P5, and P7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy IC X-2 titled "Employee Screening: New Hire and Ongoing" last reviewed/revised 9/19/2007, provided in pertinent part on page 1, "The screening will determine immunization status and history of conditions that may predispose personnel to acquiring or transmitting communicable diseases". 2. P2's was hired on 6/11/2002 and P2's personnel file: <ol style="list-style-type: none"> a. did not contain a declination for 	S0556	<p>S 556 Immediate Corrective Action: TB Skin Test As of November 4, 2011, the TB skin test form has been changed to include administration date/time and results date/time. On November 4, 2011, all contracted agencies utilized by the organization were directed to comply with the above process. Hepatitis B and all titers On November 4, 2011, the Infection Control/Employee Health nurse was re-educated on the appropriate follow-up needed for all titers to include Hepatitis B when equivocal results are noted. Employees noted to have equivocal results will be informed to follow-up with their private physician for any necessary treatment/screening prior to the start of employment with the organization. All employees will be required to sign a declination if choosing not to receive the Hepatitis B vaccine. Further Corrective Action to prevent Recurrence/Monitoring: Beginning November 4, 2011, 100% of newly hired employee's</p>	12/03/2011

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	<p>hepatitis B vaccination.</p> <p>b. contained a laboratory titre for hepatitis B dated 6/7/2001 which was a negative result (9.9 or greater titre required to confirm immunity).</p> <p>c. lacked documentation of appropriate follow-up of the negative titre.</p> <p>3. P3 was hired on 12/1//1995 and P3's personnel file contained a TB skin test which:</p> <p>a. was documented as given on 9/12/2011.</p> <p>b. was documented as read on 9/14/2011.</p> <p>c. did not document the time on either of the above dates.</p> <p>4. P4 was hired on 10/17/2011 and P4's personnel file:</p> <p>a. did not contain a declination for hepatitis B vaccination.</p> <p>b. contained a laboratory titre for hepatitis B dated 10/4/2011 of 7.3 (10.0 or greater titre required to confirm immunity).</p> <p>c. lacked documentation of appropriate follow-up of the equivocal titre.</p> <p>5. P5 was hired on 10/4/2011 and P5's personnel file:</p> <p>b. contained a laboratory titre dated 9/22/2011 of 1.00 (1.09 or greater titre required to confirm immunity).</p> <p>c. lacked documentation of appropriate</p>		<p>files will be audited for 2 quarters by the Infection Control/Employee Health Nurse for compliance with relationship to TB skin testing and Hepatitis B and all other titers. Compliance target: 100%. Currently, all employees are current for Hepatitis B or have sign declinations. Responsible Role: Director of Quality / Human Resource Coordinator / Infection Control/Employee Health Nurse</p>				

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	<p>follow-up of the equivocal titre.</p> <p>6. P7 was hired on 4/20/2010 and P7's personnel file contained a TB skin test which:</p> <p>a. was documented as given on 8/23/2011.</p> <p>b. was documented as read on 8/25/2011.</p> <p>c. did not document the time on either of the above dates.</p> <p>7. P10 was an agency RN who worked in the facility during 9/2011 and P10's personnel file:</p> <p>a. contained a TB skin test documented as given 1/17/2011</p> <p>b. was documented as read on 1/20/2011.</p> <p>c. did not document the time on either of the above dates.</p> <p>8. During interview with S9 on 11-2-2011 at 2:00 PM, S9:</p> <p>a. verified the above findings</p> <p>b. stated that the TB skin test result could not reliably be determined to have been read between 48 and 72 hours per CDC guidelines without documentation of the time given and the time read.</p> <p>c. negative or equivocal titres required follow-up to reliably determine the communicable disease status of employees or agency personnel and that the appropriate follow-up was not done in the above.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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S0871	<p>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:</p> <p>(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.</p> <p>(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 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 medical record reveiw and</p>	S0871	S 871 Immediate Corrective Action: All physicians will be	12/03/2011	

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	<p>interview, the facility failed to ensure that physician's verbal orders were authenticated in accordance with hospital policy in six (6) of twenty-six (26) medical records reviewed (N4, N14, N16, N17, N18, and N19).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Facility policy "Verbal and Telephone Orders" last reviewed/revised 10/8/2010, provides on page 1, D, in pertinent part "All verbal or telephone orders will be "Read Back & Verified" to the ordering practitioner to ensure the accuracy of the order" and on page 2, E, "all orders (including verbal) require a date, time, and authentication". N4 was admitted on 8/20/2011 and expired on 9/24/2011, and N4's medical record contained: <ol style="list-style-type: none"> pre and post PICC line insertion telephone orders dated 8/23/2011 which were not authenticated. a telephone order for an operative consent dated 9/11/2011 which was not authenticated. a telephone order to discontinue Coumadin, give FFP, Vit. K, and ordering laboratory tests which was not authenticated. N14 was admitted 7/8/2011 and and 		<p>re-educated on the appropriate authentication of verbal and telephone orders which include dates, times as well as authentication of orders within thirty days of patient's discharge. All nursing staff will be re-educated on the Read Back and Verify process which include all verbal and telephone orders. Further Corrective Action to prevent Recurrence/Monitoring: To prevent further deficiency form occurring in the future, Health Information Management in collaboration with the Nursing Department will perform monthly audits for 2 quarters or until the target is met. These audits will focus on authentication of orders as well as the Read Back and Verify process. The target for compliance will be set at 90%. Results will be reported to the HIM, Quality, MEC committees in addition to the Governing Board. Responsible Role: CEO/CCO/HIM Manager</p>				

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	<p>expired on 7/10/2011, and N14's medical record contained:</p> <p>a. a telephone order dated 7/9/2011 for a laboratory test and change in ventilator setting which were not authenticated.</p> <p>b. a telephone order dated 7/9/2011 for laboratory tests which was not authenticated.</p> <p>c. a telephone order dated 7/10/2011 for Lopressor which was not authenticated.</p> <p>d. a telephone order dated 7/10/2011 to start Levophed per protocol which was not authenticated.</p> <p>4. N16 was admitted 8/25/2011 and and discharged on 9/23/2011, and N16's medical record contained:</p> <p>a. a telephone order dated 8/26/2011 for colostomy care which was not authenticated.</p> <p>b. a telephone order dated 9/11/2011 for TPN and laboratory tests which was not authenticated.</p> <p>c. a telephone order dated 9/23/2011 for a bedside commode for home use which was not authenticated.</p> <p>5. N17 was admitted 5/27/2011 and and discharged on 6/22/2011, and N17's medical record contained a telephone order for Kayoxylate and to hold blood pressure medication this evening which was signed by the physician but not dated</p>				

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	<p>and timed by the physician.</p> <p>6. N18 was admitted 7/22/2011 and discharged on 8/9/2011, and N18's medical record contained:</p> <p>a. a telephone order dated 7/23/2011 regarding the patient's PICC line which was not authenticated.</p> <p>b. a telephone order dated 7/24/2011 for Endural LA to be changed from 60mg to 20 mg t.i.d. p.o. which was signed by the physician but not dated and timed.</p> <p>c. a telephone order dated 8/1/2011 for Bactroban which was signed by the physician but not dated and timed.</p> <p>d. a telephone order dated 8/2/2011 for K-Rider and a laboratory test which was signed by the physician but not dated and timed.</p> <p>e. a telephone order dated 8/3/2011 for a repeat potassium laboratory test which was signed by the physician but not dated and timed. The order was written by an RN was signed "Dr. Vyas/RBrown RN" and was not identified as a telephone or verbal order and had no documentation that the "Read Back & Verify" process had been used as per policy.</p> <p>f. a telephone order dated 8/4/2011 for dressing changes which was signed by the physician but not dated and timed.</p> <p>g. a telephone order dated 8/8/2011 for K-dur which was signed by the physician but not dated and timed.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>h. a telephone order dated 8/8/2011 to discontinue IV antibiotics which was not authenticated.</p> <p>i. a telephone order dated 8/9/2011 to discharge home which was not authenticated.</p> <p>7. N19 was admitted 7/19/2011 and discharged on 8/9/2011, and N19's medical record contained:</p> <p>a. a telephone order dated 7/25/2011 for a stat laboratory test which was not authenticated.</p> <p>b. a telephone order dated 7/27/2011 for Nepro i can BID which was not authenticated.</p> <p>c. a telephone order dated 8/2/2011 to discontinue nicotine patch which was not authenticated.</p> <p>d. a telephone order dated 8/4/2011 for dressing care which was signed by the physician but not dated and timed.</p> <p>e. a telephone order dated 8/26/2011 for a dressing to left forearm which was not authenticated.</p> <p>8. During interview with S10 on 11/3/2011 at 1:48 PM, S10:</p> <p>a. verified the above findings</p> <p>b. stated that the date orders were signed could not be determined without documentation of the date and time authenticated by the person responsible for the order.</p>				

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S0872	<p>410 IAC 15-1.5-5(b)(3)(P)</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>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on medical record review and interview, the facility failed to ensure that physician's orders were authenticated in accordance with hospital policy in five (5) of twenty-six (26) medical records reviewed and that the medical record was</p>	S0872	S 872 Immediate Corrective Action: All physicians will be re-educated on the appropriate authentication of verbal and telephone orders which include dates, times as well as authentication of orders within	12/03/2011

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	<p>complete within 30 days following discharge (N4, N14, N16, N21, and N26).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "HIM; Complete Medical Records Definition" states in pertinent part on page 1, B, 1 "The time and date of each entry (orders, reports, notes, etc.) must be accurately documented" and on page 1, B, 2 " All entries in the medical record must be dated, times, and appropriately authenticated by the person who is responsible for ordering, providing, or evaluating the service provided". 2. N4 was admitted on 8/20/2011 and expired on 9/24/2011. N4's medical record contained an operative report for a tracheostomy dictated on 9/15/2011 which had not been authenticated. 3. N14 was admitted 7/8/2011 and expired on 7/10/2011, and N4's medical record contained an operative report dictated on 9/15/2011 which had not been authenticated. 4. N16 was discharged 9/23/2011, and N16's medical record contained a discharge summary dated 9/23/2011 which had not been authenticated. 		<p>thirty days of patient's discharge. All nursing staff will be re-educated on the Read Back and Verify process which include all verbal and telephone orders. Further Corrective Action to prevent Recurrence/Monitoring: To prevent further deficiency form occurring in the future, Health Information Management in collaboration with the Nursing Department will perform monthly audits for 2 quarters or until the target is met. These audits will focus on authentication of orders as well as the Read Back and Verify process. The target for compliance will be set at 90%. Results will be reported to the HIM, Quality, MEC committees in addition to the Governing Board. Responsible Role: CEO/CCO/HIM Manager</p>		

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	<p>5. N21 was discharged 6/27/2011, and N21's medical record contained:</p> <p>a. a procedure note dated 6/21/2011 which had not been authenticated.</p> <p>b. a discharge summary dated 6/27/2011 which had not been authenticated.</p> <p>6. N26 was discharged on 9/17/2011 and N26's medical record contained a consultation report dictated on 9/7/2011 which had not been authenticated by the physician.</p> <p>7. During interview with S10 on 11/3/2011 at 1:48 PM, S10 verified the above findings.</p>				