

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2012
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN 46544		
(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	
S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/23/2012 through 10/24/2012</p> <p>Facility Number: 002605</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 11/14/12</p>	S0000	Submission on 11/29/2012		

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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and staff interview, the facility failed to ensure 2 contracted hospital services were submitted to the Governing Board for review as defined in the Strategic Plan For Quality 2012.</p> <p>Findings included:</p> <p>1. The 2012 Strategic Plan For Quality indicates facilitating documentation and reporting of performance improvement activities to the Board of Directors. The Board of Directors will annually review and identify</p>	S0270	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana</p> <p>Hospital License #132-6051 Facility #002605</p> <p>INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S270: Completion Date Correction of Deficiency</u> October 30, 2012 The Laundry and Housekeeping contracted services met with Administration on October 30, 2012. November 28, 2012</p>	11/19/2012	

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	<p>organizational improvement opportunities that will provide the focus for performance improvement activities for the hospital. Performance Improvement Team provides their results to the Medical Staff for review before it would be submitted to the Governing Board.</p> <p>2. At 2:15 PM on 10/24/2012, staff member #3 provided the Regular Meeting of The Governing Board April 5, 2012 minutes. Line Item of the minutes, Performance Improvement/Committee, states, "Medical Staff performance improvement results through December 31, 2011 were reported via the Governing Board dashboard report. Dashboard is attached to the minutes. The Governing Board approved the Medical Staff Performance Improvement report, as submitted. The attached report did not identify the contracted services laundry/linen and housekeeping.</p>		<p>November 28, 2012 Ongoing Laundry: Laundry submitted a titration report of operation, time, temperature set and actual level set and actual chemical information, quantity, active alk (ppm), inactive alk (ppm) and pH. The report was reviewed and approved at the Infection Prevention Committee on November 28, 2012. The report will be submitted monthly to the Infection Prevention Committee and quarterly to the Clinical Quality Committee and the Governing Board. (Attachments 1 and 2).</p> <p>Review Completed review of Aramark Titration report at Infection Prevention Committee.</p> <p>Corrective Action / Monitoring November 28, 2012 Aramark Titration report at monthly Infection Prevention Meeting, quarterly at Clinical Quality Council and Governing</p>				

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	3. At 2:25 PM on 10/24/2012, staff member #3 confirmed laundry/linen and housekeeping contracted services were not evaluated and submitted to the Medical Staff nor the Governing Board for review.		<p>Board.</p> <p>Chief Executive Officer to meet semi-annually with Aramark.</p> <p>-</p> <p>Responsible Person(s)</p> <p>Christine Voorde – Chief Executive Officer Suzanne Morgan, Director Quality Management</p> <p>November 20, 2012</p> <p>December 1, 2012</p> <p>Housekeeping: Housekeeping will submit a Quality Report monthly of: ü number of rooms inspected. ü person performing (Attachment 3)</p> <p>A monitor has been established and approved by the Clinical Quality Council on November 20, 2012. (Attachments 4 and 5)</p> <p>The report will be submitted monthly to the Infection Prevention Committee and quarterly to the Clinical Quality Council and the Governing Board.</p>		

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			<p>December 2, 2012 Review The Director Quality Management to review initial report with Director Environmental Services of Saint Joseph Regional Medical Center (SJPMC) – contracted service.</p> <p>Corrective Action / Monitoring December 19, 2012 SJPMC Housekeeping Report at monthly Infection Prevention Meeting. Quarterly to Clinical Quality Council and Governing Board.</p> <p>Responsible Person(s) Suzanne Morgan, Director Quality Management</p>		

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(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:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on policy review, administrative document review, and interview, the governing board failed to ensure housekeeping policies were in place and approved to maintain environmental safety.</p> <p>Findings included:</p> <p>1. Review of the facility's policies and procedures failed to indicate any housekeeping procedures or guidelines. Review of the facility's infection control policies only indicated a list of chemicals with MSDS (Material Safety Data Sheets) used by the contracted housekeeping service.</p> <p>2. Review of the Environmental Services Agreement, signed 12/03/09, indicated, "...19. Supplies- As part of this</p>	S0322	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana</p> <p>Hospital License #132-6051 Facility #002605</p> <p>INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S322: Completion Date Correction of Deficiency</u> November 20, 2012</p> <p>The policies and procedures for Saint Joseph Regional Medical Center (SJPMC) were reviewed and approved at the Clinical Quality Council. (Attachment 6)</p> <p>The Chemical List was reviewed</p>	11/15/2012			

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	<p>Agreement, [Contract facility] shall provide all equipment, tools, and cleaning supplies. [Contract facility] shall also provide MSDS sheets to [hospital] for all cleaning materials to be used." The contract contained an attachment, "Exhibit A- Services", which indicated, "...3. Housekeeping Services- [Contract facility] shall be responsible for providing housekeeping services to [hospital] on a daily basis to maintain [hospital] in a clean and acceptable condition. The specific housekeeping services and the schedule of such housekeeping services shall be mutually agreed upon by [Contract facility] and [hospital].</p> <p>3. At 11:00 AM on 10/24/12, the Environmental Services Supervisor of the contracted service, staff member #A9, brought copies of training material. He/she indicated staff were trained using the "7 Step Cleaning" document and this was also reviewed annually with them. This 2- page document indicated to use "germicidal cleaner" to wipe surfaces, but did not specify what was to be used in the bathrooms or on the floors. The document was generic and did not discuss any chemical usage, kill times, or specific directions.</p> <p>4. At 11:45 AM on 10/24/12, staff members #A1 and A2 indicated the</p>		<p>and approved at the Clinical Quality Council.</p> <p>November 28, 2012</p> <p>December 15, 2012</p> <p>The Infection Prevention Committee reviewed the list of cleaning products.</p> <p>Review The policies, procedures and chemical list will be reviewed and approved annually by the Infection Prevention Committee.</p> <p>Corrective Action / Monitoring December 1, 2012 The Infection Preventionist will monitor a minimum of two observations per month to ensure cleaning is carried out in accordance with the policy.</p> <p>-</p> <p>Responsible Person(s) Diana Korpai, RN, CIC, Infection Preventionist</p>	

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	facility did not have its own housekeeping policies, but relied on the contracted services. They indicated they did not know of any other document specifying "mutually agreed upon services". The staff members indicated they did not know specifics regarding chemicals or kill times and had never actually observed the housekeeping step-by-step procedures.			

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to ensure 2 services provided by contractors were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Kindred Hospital Northern Indiana 2012 A Strategic Plan for Quality implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p>	S0406	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #132-6051 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S406: Completion Date Correction of Deficiency</u></p> <p>October 30, 2012 The Laundry and Housekeeping contracted services met with Administration on October 30, 2012.</p> <p>November 28, 2012 November 28, 2012</p> <p>Ongoing Laundry: Laundry submitted a titration report of operation, time, temperature set and actual level set and actual chemical information, quantity, active alk (ppm), inactive alk (ppm) and pH. The report was</p>	12/03/2012
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	<p>2. Review of the facility's QA&I program indicated it did not include contracted services laundry/linen and housekeeping services.</p> <p>3. At 2:00 PM on 10/24/2012, staff member #3 indicated housekeeping and laundry/linen contracted services were not evaluated through the hospital's QA&I process.</p>		<p>reviewed and approved at the Infection Prevention Committee on November 28, 2012. The report will be submitted monthly to the Infection Prevention Committee and quarterly to the Clinical Quality Committee and the Governing Board. (Attachments 1 and 2). Review Completed review of Aramark Titration report at Infection Prevention Committee. Corrective Action / Monitoring November 28, 2012 Aramark Titration report at monthly Infection Prevention Meeting, quarterly at Clinical Quality Council and Governing Board. Chief Executive Officer to meet semi-annually with Aramark. _ Responsible Person(s) Christine Voorde – Chief Executive Officer Suzanne Morgan, Director Quality Management November 20, 2012 December 1, 2012 Housekeeping: Housekeeping will submit a Quality Report monthly of: ù number of rooms inspected. ù person performing (Attachment 3) A monitor has been established and approved by the Clinical Quality Council on November 20, 2012. (Attachments 4 and 5) The report will be submitted monthly to the Infection Prevention Committee and quarterly to the Clinical Quality Council and the Governing Board.</p>		

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			<p>December 2, 2012 <u>Review</u>The Director Quality Management to review initial report with Director Environmental Services of Saint Joseph Regional Medical Center (SJRCM) – contracted service.</p> <p><u>Corrective Action / Monitoring</u></p> <p>December 19, 2012 SJRCM Housekeeping Report at monthly Infection Prevention Meeting. Quarterly to Clinical Quality Council and Governing Board.</p> <p><u>Responsible Person(s)</u> Suzanne Morgan, Director Quality Management</p>		

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <p>1. During the tour of the Medical/Surgical Unit at 9:00 AM on 10/24/12, accompanied by staff member #A2, the following items were observed in the medication room:</p> <p>A. Para Pak containers with media for stool culture and sensitivity, 12 of 12, with an expiration date of 05/2012.</p> <p>B. Remel Saf-Fixative for parasites, 8 of 8, with an expiration date of 04/11/12.</p> <p>C. Para Pak containers with media for stool culture and sensitivity, 9 of 9, with an expiration date of 02/2012.</p> <p>2. During the tour of the High Observation Unit at 9:50 AM on 10/24/12, accompanied by staff members #A1 and A2, the following items were observed:</p> <p>A. BD Insyte Autoguard- 18 gauge, 5 of</p>	S0554	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana</p> <p>Hospital License #132-6051 Facility #002605</p> <p>INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S554: Completion Date Correction of Deficiency October 24, 2012</u></p> <p>All outdated materials found in the High Observation Medication Room, the Medical Surgical Medication room and the Radiology Department were removed that same day, 10/24/2012, by Jane Mason, Chief Clinical Officer, (Medication Rooms), and John Kudelka (Radiology Department).</p> <p><u>Review November 10, 2012</u></p>	12/05/2012	

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	<p>5, two with an expiration date of 04/2012 and three with an expiration date of 08/2012, in the clean supply room.</p> <p>B. In a container on a shelf in the medication room, 1 of 1 blue top lab tubes with an expiration date of 05/2012 and 2 of 2 yellow top lab tubes with an expiration date of 04/2012.</p> <p>C. In a drawer in the medication room:</p> <ol style="list-style-type: none"> 1. Para Pak containers with media for stool culture and sensitivity, 2 of 2, with an expiration date of 02/2012. 2. Remel Saf-Fixative for parasites, 6 of 6, with an expiration date of 04/11/12. 3. Copan sterile swab applicators , 8 of 8, with an expiration date of 02/2012. 4. BD Bactec anaerobic bottle with medium, 1 of 1, with an expiration date of 12/31/2011. 5. Two small blue top lab tubes with medium, 1 with an expiration date of 05/2011 and 1 with an expiration date of 06/2011. <p>3. During the tour of the Radiology Department at 10:30 AM on 10/24/12, accompanied by staff members #A1, A2, and A13, the following items were observed:</p> <ol style="list-style-type: none"> A. BD Insyte Autoguard- 22 gauge, 29 of 30, one with an expiration date of 06/2012 and 28 with an expiration date 07/2012, in the medication cart. B. Electrocardiograph (ECG) Conductive 		<p>November 28, 2012</p> <p>November 20, 2012</p> <p>On random rounds, all supply rooms were checked for outdates by Materials Management; none were found. 80 items reviewed; 80 items in compliance.</p> <p>On random rounds, all supply rooms were checked for outdates by Materials Management; none were found. 85 items reviewed; 85 items in compliance.</p> <p>Changes: Reminder to Pharmacy, Lab, Materials Management to check for outdates on the first day of every month.</p> <p>Corrective Action / Monitoring December 3, 2012 ongoing</p> <p>December 3, 2012 ongoing</p> <p>November 1, 2012</p>		

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	<p>Adhesive, 1 of 1 unopened packages, with an expiration date of 07/2012, on the cardiac ultrasound machine.</p> <p>The supervisor of the department, staff member #A13, indicated the techs were responsible for checking the supplies.</p> <p>4. At 11:00 AM on 10/24/12, staff member #A2 indicated the materials management staff checked and replenished the supplies on a regular basis, but confirmed the outdated items.</p>		<p>December 5, 2012 ongoing</p> <p>On the first business day of each month, the Nurse Manager will ensure that the medication rooms on both High Observation and the Medical Surgical Units are checked for outdated supplies.</p> <p>On the first business day of each month, the Radiology Supervisor will ensure that the Radiology Department will be checked for outdated supplies.</p> <p>Materials Management initiated a new format for identifying outdates on crash carts. (Attachment 7)</p> <p>The results will be reported to the Patient Care and Safety Committee monthly.</p> <p>-</p> <p><u>Responsible Person(s)</u></p> <p>Jane Mason, Chief Clinical Officer</p> <p>11/29/2012</p>		

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S0596	<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: (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 policy and procedure review, administrative document review, manufacturer's recommendations, training records, and interview, the infection control committee failed to ensure the patient care areas were cleaned and disinfected according to acceptable standards of practice.</p> <p>Findings included:</p> <p>1. Review of the facility's policies and procedures failed to indicate any housekeeping procedures or guidelines. Review of the facility's infection control policies only indicated a list of chemicals with MSDS (Material Safety Data Sheets) used by the contracted housekeeping service. At 2:00 PM on 10/23/12, the</p>	S0596	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #132-6051 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S596: Completion Date Correction of Deficiency November 20, 2012 Policies & Procedures:</u> The Environmental Services policies and procedures for Saint Joseph Regional Medical Center were reviewed and approved at the Clinical Quality Council. (Attachment 6). The Chemical List was reviewed and approved at the Clinical Quality Council.</p>	12/14/2012			

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	<p>Infection Prevention Nurse, staff member #A5, indicated he/she did not have cleaning policies and procedures specific to this facility and had not observed the cleaning staff to determine if they used the proper chemicals appropriately.</p> <p>2. Review of the Environmental Services Agreement, signed 12/03/09, indicated, "...19. Supplies- As part of this Agreement, [Contract facility] shall provide all equipment, tools, and cleaning supplies. [Contract facility] shall also provide MSDS sheets to [hospital] for all cleaning materials to be used." The contract contained an attachment, "Exhibit A- Services", which indicated, "...3. Housekeeping Services- [Contract facility] shall be responsible for providing housekeeping services to [hospital] on a daily basis to maintain [hospital] in a clean and acceptable condition. The specific housekeeping services and the schedule of such housekeeping services shall be mutually agreed upon by [Contract facility] and [hospital].</p> <p>3. Review of the training records for housekeeping staff members #A11, A12, and A23, who cleaned at the facility, failed to indicate any training or guidelines specific to cleaning that facility.</p>		<p>November 28, 2012 The Infection Prevention Committee reviewed the list of cleaning products.</p> <p>Review</p> <p>December 15, 2012 The policies, procedures and chemical list will be reviewed and approved annually by the Infection Prevention Committee.</p> <p>Corrective Action / Monitoring</p> <p>December 1, 2012 The Infection Preventionist will monitor a minimum of two observations per month to ensure cleaning is carried out in accordance with the policy.</p> <p>Responsible Person(s) Infection Preventionist</p> <p>Education of Employees</p> <p>December 15, 2012 November 20, 2012 October 30, 2012 7</p> <p>Step Process: The contracted employees will be educated in the 7 Step process of cleaning. ReviewThe 7 Step process was approved at the Clinical Quality Council. ChangesThe supervisor for Saint Joseph Regional Medical Center (SJRM) environmental services will meet monthly to review any changes in policies and procedures.</p> <p>Corrective Action / Monitoring</p> <p>November 29, 2012 ongoing Education program (annually) for contracted employees for 7 Step process of cleaning. (Attachment 8)Concurrent review for compliance of employees will</p>				

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	<p>4. During the tour of the High Observation Unit at 10:00 AM on 10/24/12, accompanied by staff members #A1, A2, and housekeeping staff member #A11, the cleaning supplies in the housekeeping closet were checked. Staff member #A11 indicated the HB Quat Disinfectant was used for surface cleaning and the areas should remain wet for 10 seconds. He/she indicated the 4L Bathroom Cleaner was sprayed on surfaces and remained for 20 seconds, but the 5 1 L Bathroom Cleaner could also be used on the bathroom surfaces. The manufacturer's directions for the HB Quat Disinfectant and 4L Bathroom Cleaner indicated the surfaces should remain wet for 10 minutes for optimum effectiveness. The 5 1 L Bathroom Cleaner did not list any disinfecting properties. Staff member #A11 indicated the 3H Neutral Cleaner was used to mop the floors, but its label also lacked any disinfecting properties.</p> <p>5. At 10:10 AM on 10/24/12, another housekeeping staff member, #A12, was interviewed on the unit. He/she indicated the 5 1 L Bathroom Cleaner (the one without the disinfecting properties) was used on the bathroom surfaces and it was allowed to sit for 5 minutes, then was wiped dry. When questioned about a bucket of pink solution with a mop sitting in it located inside the housekeeping</p>		<p>occur during Safety Rounds or as needed.</p> <p>Responsible Person(s) Suzanne Morgan, Director, Quality Management Diana Korpai, Infection Preventionist</p>		

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	<p>closet, staff member #A12 indicated he/she had used it 2 days ago to clean up a spill in the dialysis room. He/she indicated the water contained the 8L General Purpose Cleaner (which did not contain any disinfecting properties). He/she indicated some distilled water was spilled and the floor was sticky so he/she was asked to clean it up.</p> <p>6. At 11:00 AM on 10/24/12, the Environmental Services Supervisor of the contracted service, staff member #A9, brought copies of training material. He/she indicated staff were trained using the "7 Step Cleaning" document and this was also reviewed annually with them. This 2- page document indicated to use "germicidal cleaner" to wipe surfaces, but did not specify what was to be used in the bathrooms or on the floors. The document was generic and did not discuss any chemical usage, kill times, or specific directions.</p> <p>7. At 11:45 AM on 10/24/12, staff members #A1 and A2 indicated the facility did not have its own housekeeping policies, but relied on the contracted services. They indicated they did not know of any other document specifying "mutually agreed upon services". The staff members indicated they did not know specifics regarding chemicals or kill</p>			

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	times and had never actually observed the housekeeping step-by-step procedures.				

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure high-protein nutritional tube supplements were stored properly in the Dry Storage Room of the Materials Handling Department.</p>	S0610	<p>Mishawaka, Indiana Hospital License #132-6051 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p>S610: Completion Date Correction of Deficiency October 24, 2012 completed October 24, 2012 completed</p>	11/19/2012			

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	<p>Findings included:</p> <ol style="list-style-type: none"> At 12:15 PM on 10/24/2012, the basement Materials Handling Department was toured. The top shelf of a storage rack was observed storing assorted nutrient tube-feeding supplements: Vital 1.2; Jevity; Nepro; and Glucernal 1.5. The assorted items were removed from their cases and were placed on the shelf of the storage rack. Above the storage rack and other locations throughout the Materials Handling room were 4-bulb ceiling mounted fluorescent light fixtures. The manufacturer's label of Abbott Nepro with Carb Teady Therapeutic Nutrition Vital Tolerance states, "Contains light-sensitive nutrients." At 11:55 AM on 10/24/2012, staff member #18 indicated there were 44 liters of assorted nutritional tube feeding supplements stored on the shelf 		<p>October 24, 2012 completed All tube feedings in basement storage area were removed from the shelves. Policy addendum completed to reflect the light sensitive materials. (Attachment 9). ReviewThe feedings were removed per Materials Management and the Dietician. ChangesThe procedure for storing feedings was changed to keep them in the box until delivery to the cupboard. Corrective Action / Monitoring November 19, 2012 completed Education to RNs and LPNs about light sensitivity reviewed on "light-sensitive nutrients."during Safety rounds will observe for nutrients being in cupboard. Responsible Person(s) Dietician</p>		

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	under the room's fluorescent bright lights and the staff member confirmed the assorted liquid tube feeding supplements all contained light-sensitive nutrients.			

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S0754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(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.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all patient records contained an appropriately executed Consent for Admission and Treatment in 7 of 12 closed medical records reviewed (#N4, N5, N6, N8, N10, N11, and N12).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Patient Admissions, Discharges, and Transfers", last reviewed June 2012, indicated, "...c) Completing Admission Forms-...Ensure that all fields are completed on admission documents and that the documents are signed by the patient/representative upon admission." The medical record for patient #N4 indicated the Consent for Admission and 	S0754	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #132-6051 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S754: Completion Date</u> <u>Correction of Deficiency</u> October 30, 2012 completed November 1, 2012 completed November 5, 2012 completed The Director Quality Management and the Clerical Coordinators reviewed the present process flow of completion for the "Consent for Admission and Treatment." Review The process was reviewed and changes made to meet the rule. ChangesAt the time of admission, the "Consent for Admission and Treatment" will</p>	11/26/2012
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	<p>Treatment form signed by the patient on 06/16/12, but lacked a name and signature of a witness with a date.</p> <p>3. The medical record for patient #N5, admitted 08/10/12, lacked documentation of a Consent for Admission and Treatment form.</p> <p>4. The medical record for patient #N6 indicated the Consent for Admission and Treatment form signed by two daughters of the patient on 07/01/12, but lacked a name and signature of a witness with a date.</p> <p>5. The medical record for patient #N8 indicated the Consent for Admission and Treatment form signed by the patient on 06/19/12, but lacked a name and signature of a witness with a date.</p> <p>6. The medical record for patient #N10 indicated the Consent for Admission and Treatment form signed by the patient on 05/29/12, but lacked a name and signature of a witness with a date.</p> <p>7. The medical record for patient #N11 indicated the Consent for Admission and Treatment form signed by the husband of the patient on 07/01/12, but lacked a name and signature of a witness with a date.</p>		<p>print to the Medical Surgical nurses station. The Clerical Coordinator will be responsible for obtaining consent from patient and/or POA. At the end of each shift, the Clerical Coordinator will report any pending signatures to the Director Quality Management.</p> <p><u>Corrective Action / Monitoring</u> November 15, 2012 completed November 19, 2012 completed November 26, 2012 ongoing Education to Clerical Coordinators:— importance of Consent— who can sign Consent: family/patient/POA— process flow— timeliness of completion— witness signature Daily concurrent monitoring of completed consents, with evidence of:— proper signature— witness 100% compliance of all Consents completed appropriately and within 24 hours per policy and procedure.</p> <p><u>Responsible Person(s)</u> Suzanne Morgan, Director Quality Management</p>		

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	<p>8. The medical record for patient #N12 indicated the Consent for Admission and Treatment form signed by the patient on 07/26/12, but lacked a name and signature of a witness with a date.</p> <p>9. At 3:10 PM on 10/24/12, staff member #P3 indicated the forms should have been witnessed by the hospital staff member obtaining the consent.</p> <p>10. At 4:00 PM on 10/24/12, staff members #P2 and P6, the person navigating the Electronic Medical Record, confirmed the lack of a consent for patient #N5 and the lack of witnesses on the other consents.</p>				

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to ensure staff followed their policy for blood administration in 4 of 5 records reviewed of patients who had received blood transfusions (#N1, N2, N4, and N5).</p> <p>Findings included:</p> <p>1. The facility policy "Blood and Blood Product Administration", last reviewed May 2012, indicated, "...7. RBC [Red Blood Cells] bags sent in coolers, to those areas where blood products will be held at the bedside, will contain hemotemp stickers. Safe temperature range is 1- 6 degrees C. [Celsius]. If the temperature is 7- 9 degrees C, call blood bank prior to administration. Document temperature verification on the yellow blood product information form and send form to lab. ...E. Vital signs (TPR & BP) [Temperature, Pulse, Respirations & Blood Pressure] are to be taken and recorded within 60 minutes prior to initiation of each unit of blood/blood product, 15 minutes after start of each unit, and at the completion of each unit. F. The transfusionist is to remain with patient for a minimum of 5 minutes (15 preferred) after initiation of transfusion and observe for any</p>	S0952	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #132-6051 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION November 2012</p> <p><u>S952: Completion Date Correction of Deficiency November 10, 2012</u> The "Blood and Blood Product Administration Policy and Procedure" stated vital signs (TPR & BP) are to be taken and recorded within 60 minutes of initiation, fifteen minutes after the start of each unit, and at the completion. The transfusionist was to remain with the patient for at least five minutes after the start of the unit.</p> <p><u>Review November 10, 2012</u> Documentation between the electronic medical record and the</p>	12/03/2012
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	<p>signs/symptoms of reaction or patient distress. G. The patient must be observed by an RN [Registered Nurse] or LPN [Licensed Practical Nurse] a minimum of every 1 hour during transfusion."</p> <p>2. The Electronic Medical Record (EMR) for patient #N1 indicated a nursing entry that a unit of blood, #W045212006477, was started at 1210 on 04/26/12. The Transfusion Record lacked documentation for the Date/Time Started, Date/Time Stopped, and Signature of Person Discontinuing Blood. The form indicated 1408 for pre-transfusion vital signs and 1425 for 15-minute vital signs, which were 2 hours after the start time recorded in the EMR. The record also lacked documentation of the transfusionist remaining with the patient for 5 to 15 minutes.</p> <p>3. The EMR for patient #N2 indicated a nursing entry that a unit of blood, #W045212010630, was started at 1700 on 06/08/12. The Transfusion Record indicated 1655 as the start time, 1655 for pre-transfusion vital signs, and 1515 for the 15-minute vital signs, which was before the blood was even started. The record also lacked documentation of the transfusionist remaining with the patient for 5 to 15 minutes.</p> <p>4. The Transfusion Record for patient #N4 indicated a unit of blood, #W045212011815, was started at 2245 on 06/15/12, pre-transfusion vital signs were at 2245 and 15 minute vital signs were at 2315, 30 minutes after the start of the unit. The form also indicated the transfusion was completed at 0135 on 06/16/12, but the post-transfusion vital signs were documented as 0125, ten minutes earlier.</p> <p>5. The Transfusion Record for patient #N5 indicated a unit of blood, #W045212018957, was</p>		<p>blood bank records were not consistent:— Vital signs pre-transfusion— Vital signs 15 minutes after start of transfusion— Vital signs hourly and post-transfusion Blood and Blood Product Administration Policy and Procedure of 6/2012 reviewed (Attachment 10).</p> <p>Changes November 10, 2012 The Blood and Blood Product Administration Policy and Procedure was reviewed and updated with changes about transportation and temperature of blood. November 1, 2012 The South Bend Medical Foundation Director (Laboratory Contract Services), Chief Clinical Officer, Nurse manager, and Director Quality Management met to review blood administration process. The process was determined to meet the standards outlined in the policy and procedure. November 20, 2012 The Blood and Blood Product Administration Policy and Procedure was reviewed and approved by Medical Executive Committee on November 7, 2012.</p> <p>Corrective Action / Monitoring December 3, 2012 Education Program for (annual) blood administration to all RNs and LPNs to be reviewed:a) Vital signs pre-during and-post transfusion.b) Informed Consentc) Staying with patient at start of transfusion.d)</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN 46544		
(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>started at 1640 on 08/17/12, but the pre-transfusion vital signs were documented as 1500, greater than 60 minutes prior to the start of the transfusion. Another Transfusion Record indicated a unit of blood, #W045212019267, was started at 2346 on 08/24/12, but the pre-transfusion vital signs were documented as 2350. The 15 minute vital signs were documented as 0015, thirty minutes after the start of the transfusion. There was no time listed for the post-transfusion vital signs nor was there a Date/Time Stopped or Signature of Person Discontinuing Blood. On 08/26/12, a unit of blood, #W045212016593, was originally listed on the form with a Hemo Temp of 7- 9 degrees, but that was crossed out and 4- 6 was written in. The Transfusion Record indicated that unit was started at 1530 on 08/26/12 with pre-transfusion vital signs at 1530 and 15 minute vital signs at 1600, thirty minutes after the start of the transfusion. The record lacked documentation of the transfusionist remaining with the patient for 5 to 15 minutes or a nurse observing the patient every hour.</p> <p>6. At 3:00 PM on 10/24/12, staff members #A2 and A6 confirmed the medical record findings and the discrepancies with the charting and times recorded. Staff member #A2 confirmed the facility's policy did not specify what nursing documentation was required to ensure the transfusionist stayed with the patient 5- 15 minutes and observed the patient at least every hour.</p>		<p>Documentation on Blood Bank forms and electronic medical record.e) Documentation on Blood forms of blood issued (Attachment 11). December 3, 2012 ongoing Concurrent monitoring of 100% blood transfusions for documentation criteria. The CCO or Nurse Manager will individually counsel the RNs and LPNs who do not meet the standards. November 30, 2012 ongoing The quality monitoring reports will be submitted with an action plan by the CCO monthly for the standing agenda item under clinical services beginning with the next Clinical Quality Council meeting February 2013, and the next Patient Care and Safety Meeting November 30, 2012. (Attachment 12) Responsible Person(s) Jane Mason, Chief Clinical Officer Tonnya LaCava, Nurse Manager Suzanne Morgan, Director Quality Management</p>		