STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	04/17/2013

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KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143

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S000000	This visit was for a State hospital licensure survey. Dates: 4/15/2013 through 4/17/2013 Facility Number: 006218 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 04/22/13	S000000		

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.

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S000308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (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: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on personnel file review, contracted food service file review and interview, the facility failed to ensure all staff received hospital/departmental orientation and were competent in 4 of 9 nursing staff files reviewed (#A25, A26, A27, and A28) and in 2 of 3 food service staff files reviewed (#A5 and A30). Findings included: 1. Review of the personnel file for staff member #A25, a nurse in the Special Care Unit hired 05/2011, indicated an incomplete "Nursing Clinical Core Competency Checklist" with a written notation that it was incomplete, but "Release from Orientation" was circled rather than "Continue Orientation Program". The front of the form	S000308	Employees A25, A26, A27, A28, and contracted food service staff A5 and A30 will be given the proper components of the orientation to ensure they were compliant with hospital and departmental orientation by 5/17/2013A 100% audit will be completed on all employees and all contracted employee files to ensure that they have completed the hospital and departmental orientation. No new contracted employees will start without completing the hospital orientation and having the proper pre employment paperwork completed. The completed audit and subsequent monthly audits will be reviewed in the monthly leadership meeting for continued compliance. The Education Nurse will be responsible for compliance.	05/17/2013

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	indicated "All items to be completed by the end of the orientation period". The file lacked any further documentation regarding the incomplete form. 2. Review of the personnel file for staff member #A26, a nurse on the Med/Surg Unit hired 06/2010, indicated an incomplete "Nursing Clinical Core Competency Checklist", but "Release from Orientation" was circled rather than "Continue Orientation Program". The front of the form indicated "All items to be completed by the end of the orientation period". The file lacked any further documentation regarding the incomplete form. 3. Review of the personnel file for staff member #A27, a nurse on the Med/Surg Unit hired 04/2011, indicated an incomplete "Nursing Clinical Core Competency Checklist", but neither "Release from Orientation" nor "Continue Orientation Program" were circled. The front of the form indicated "All items to be completed by the end of the orientation period". The file lacked any further documentation regarding the incomplete form. 4. Review of the personnel file for staff member #A28, a nurse in the Special Care Unit hired 07/2008, indicated 7			

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	educational/competency forms that were signed by the employee on 03/28/11, but not completed or signed by an instructor. The file lacked any further documentation regarding the incomplete forms. 5. Review of the contracted dietary staff member #A5, with a hire date of 02/18/13, lacked any documentation of hospital orientation. 6. Review of the contracted dietary staff member #A30, with a hire date of 03/25/13, lacked any documentation of hospital or departmental orientation.			

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S000340	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(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) Safe, appropriate, and adequate transport of patients. Based on policy review, medical record review, and interview, the facility failed to ensure staff followed their policy for 3 of 3 patients who were transferred from their facility (#N10, N11, and N12). Findings included: 1. The facility policy "Transport for Services at Another Facility", last revised 12/2010, indicated, "10. For discharges, the physician will contact the receiving facility to assure that there is an accepting physician. 11. Nursing personnel will ensure the patient and/or family is informed of the transfer if the physician has not already done so. 12. The nurse will call report to the receiving facility as soon as the patient leaves per ambulance." 2. The medical record for patient #N10, who was admitted to the facility at 1651 on 02/06/13 and transferred at 2200 that	S000340	Nurse Supervisor will be responsible for facilitating discharge of a patient that is being transferred to another facility. Documentation of discharge will be completed under “Nursing Actions-Discharge Transfer Management” in Protouch and include the elements of charting summary, change of condition, family notification and receiving facility report. (5/10/2013) To prevent further deficiency, all licensed nursing personnel will be educated on the facility policy “Transport for Services at Another Facility”, documentation of required elements in Protouch and process for notification of Nurse Supervisor for discharging patient. (5/10/2013) Responsible Parties: Nurse Manager and Nurse Educator Compliance monitoring will be	05/10/2013

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	same day, indicated a written physician order for transfer and a physician's name as accepting. The medical record lacked documentation of the patient and/or family being informed and the nurse calling report to the receiving facility. 3. The medical record for patient #N11, who was admitted to the facility on 10/24/12 and transferred on 10/25/12, indicated a written physician order for transfer to a specific physician at another facility. The medical record lacked documentation of the patient and/or family being informed and the nurse calling report to the receiving facility. 4. The medical record for patient #N12, who was admitted to the facility on 11/15/12 and transferred on 12/12/12, indicated a written physician order for transfer to a another facility. The medical record lacked documentation of the patient and/or family being informed, the physician notifying the physician, and the nurse calling report to the receiving facility. 5. At 1:00 PM on 04/17/13, staff member #A3, who navigated the EMR (Electronic Medical Record) confirmed the findings. He/she indicated the facility did not have another policy regarding transferring patients or a transfer form to ensure all		achieved through Nurse Manager reviews of documentation on each patient transferred for services at another facility and will be shared with Leadership and Quality Councils on a monthly basis.	

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	items had been completed.			

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S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure the inclusion of 7 services in its comprehensive quality assessment and improvement (QA&I) program. Findings included: 1. Kindred Hospital Indianapolis South Quality Improvement Plan implements all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. Review of the facility's QA&I	S000406	CT scan, MRI and PET Scans have been added to the Radiology Dashboard. We will begin tracking turnaround time (48 hours from completion of test to report received) for the 3 diagnostic studies on May 1st and will report through our Quality Council on a monthly basis.The Radiology Manager and CCO will responsible for collecting and reporting the data. Speech Therapy and Occupational Therapy Consulting Assessments will be added to the Clinical Services Dashboard. We will begin tracking compliance of consulting assessments (completed within 72 hours of the written order) on May 1st and report through our Quality Council on a monthly basis. The Rehabilitation Manager and CCO will be responsible for collecting and reporting the	05/01/2013

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	program indicated it did not include contracted services: CT Scanner, MRI, Occupational Therapy, PET Scanner, Speech Pathology; and in-house PICC Line Services and Endoscopy Services. 3. At 1:30 PM on 4/17/2013, staff member #4 confirmed the QA documentation provided could not evidence the 7 services in question were part of its QA&I program.		data.Clarification for PICC services: PICC Lines are not a contracted service. PICC lines are currently monitored through Clinical Services and our Quality Council. Compliance with consents obtained and correct documentation of paperwork are monitored on a monthly basis. The HIM Clerk and CCO are responsible for collecting and reporting the data. Clarification of Endoscopy Services: Any endoscopic procedure is monitored and reported through Clinical Services, Medical Executive Committee and Quality Council. Compliance with consents, completed paperwork, and post procedure notes are all monitored.The HIM Clerk, CCO and DQM are responsible for collecting and reporting the data.	

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S000554	410 IAC 15-1.5-2 INFECTION CONTROL 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, policy and procedure review, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage, dating supplies according to manufacturer's directions, and storing supplies appropriately. Findings included: 1. During the tour of the second floor Med/Surg Unit, beginning at 1:15 PM on 04/15/13 and accompanied by staff members #A1 and A3, the following observations were made: A. Glucometer supplies, 2 of 2 containers of test strips and 4 of 4 control solutions, open, but not dated, in the nurses' station. B. Two of two pearl top lab tubes with an expiration date of 12/2012 in the medication room. C. Seven of seven pearl top lab tubes with an expiration date of 12/2012 in the lab room. D. One of two control solution and 1 of 1 container of test strips, open, but not dated, in the lab room.	S000554	Immediately following the survey, all lab supplies in the hospital were examined and any expired supplies were discarded. Beginning Friday, May 3, 2013, a monthly inspection of all lab supplies will be completed by the lab manager and results will be reported through Quality Council. Beginning Friday, May 3, 2013, a weekly inspection of all lab and glucometer supplies will be conducted by the Infection Control Nurse. Any supplies that are not labeled and dated will be immediately discarded. In addition, a process will be implemented for the distribution of glucometer strips and control solutions. The nurse manager will keep all glucometer strips and control solutions locked in her office. Staff will obtain those supplies only from the nurse manager and all bottles will be timed and dated upon distribution. Two sets of strips and control solutions will also be kept in the night cabinet for distribution at times when the nurse manager is not in the building. The same process will be followed so that the bottles are	05/17/2013

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	E. One of one Para-Pak specimen container with an expiration date of 10/2012 in the lab room. F. Cardboard box of supplies stored on the floor of the clean room. 2. During the tour of the third floor Med/Surg Unit, beginning at 2:20 PM on 04/15/13 and accompanied by staff members #A1 and A3, the following observations were made: A. Glucometer supplies, 6 of 6 control solutions, open, but not dated, in the nurses' station. B. Pearl top lab tubes, 85 of 85, with an expiration date of 12/2012 in the cabinet in the nurses' station. C. Cardboard box of supplies stored on the floor of the clean room. D. A box of clean pads stored on the floor of the clean linen room. 3. During the tour of the Special Care Unit, beginning at 3:10 PM on 04/15/13 and accompanied by staff members #A1 and A3, the following observations were made: A. Pearl top lab tubes, 5 of 5, with an expiration date of 09/2012 in the cabinet in the med room. B. Three of three Para-Pak specimen containers with an expiration date of 10/2012 in the med room. C. Three of three Protocol formalin		timed and dated upon distribution from the PCC nurse. The compliance results will be reported in Infection Prevention and through quality council. Nursing staff and CNA's will recieve education on the new process of obtaining strips and control tests along with re-education on dating requirements by 5/17/2013The Infection Prevention Nurse, Lab Manager and CCO will be responsible for monitoring compliance.	

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	containers with an expiration date of 10/2012 in the med room. 4. The facility policy "Point of Care Blood Glucose Testing Nova Meter", effective 07/2012, indicated, "When opening a new vial of StatStrip Glucose Test Strips, label the vial with the opened date, user initials, and discard date prior to use. There are spaces on the vial to record this necessary information. Test strips may be used for 180 days after opening or until the expiration date listed on the original vial, whichever comes first. ...When opening a new vial of StatStrip Glucose Control, label the vial with the discard date prior to use. Quality Control and Linearity Solutions may be used for 90 days after opening or until the expiration date listed on the original vial, whichever comes first." 5. At 3:30 PM on 04/15/13, staff members #A1 and A3 confirmed the observations.			

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S000596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on observation and interview, the infection control committee failed to ensure the patient care areas and medication room were cleaned and disinfected according to acceptable standards of practice. Findings included: 1. During the tour of the second floor Med/Surg Unit, beginning at 1:15 PM on 04/15/13 and accompanied by staff members #A1 and A3, the following observations were made: A. A plastic pill crusher containing a heavy residue of white powder in the locked med server in the clean and patient-ready room 221. B. A plastic pill crusher containing a	S000596	Plastic pill crushers were immediately removed from the identified patient rooms surveyed on 4/15/2013. All patient med servers have been cleaned and sanitized (5/1/2013) To prevent further deficiency with med servers, all licensed nursing personnel will be educated on the process for cleaning and disinfecting of patient medication servers/equipment on a daily basis, with medication administration and upon patient discharge. Disposable pill crushers will be provided for each patient to prevent cross-contamination. (5/15/2013) To prevent further deficiency with patient care areas, all nursing personnel will be educated on the process for cleaning and disinfecting of patient care areas	05/15/2013

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	heavy residue of white powder in the locked med server in the clean and patient-ready room 218. Also in the med server were two open, but not dated, containers of StatStrip test strips and the counter was dirty/soiled. C. A plastic pill cutter containing a heavy residue of white powder in the locked med server in the clean and patient-ready room 217. 2. During the tour of the third floor Med/Surg Unit, beginning at 2:20 PM on 04/15/13 and accompanied by staff members #A1 and A3, the following observations were made: A. Bits of paper, alcohol swabs, and trash littering the floor of the medication room. Areas of dried material were also noted on the floor. B. A bed made with clean linens was noted pushed into room 328. Also noted in the room were a bed frame without a mattress, a patient bed with soiled linens, empty bags of intravenous solution/medication hanging on a pole, a urinal containing urine, and other patient care items. 3. At 2:00 PM on 04/15/13, staff member #A8 indicated the nurses used the disinfectant wipes to clean the med servers when a patient was discharged because they were locked cabinets and the		on a daily basis, as needed and upon patient discharge. (5/15/2013) Responsible Parties: Infection Prevention Nurse and Nurse Manager Compliance monitoring will be achieved through random weekly auditing of med server and patient care area cleanliness by Infection Prevention Nurse and will be shared with Leadership and Quality Councils on a monthly basis.	

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	housekeepers did not have access to them. 4. At 2:45 PM on 04/15/13, housekeeping staff member #A12 indicated their staff mopped the floor of the medication room daily, but the nurses had to let them in to do it. He/she also indicated housekeeping staff did not move beds so they would not be able to clean a discharged patient's room with extra beds stored in the room.			

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S000610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on documentation review, observation, and staff interview, the hospital's Dietary Department failed to ensure ground beef meatloaf was cooked to the required temperatures defined in 410 IAC 7-24 and per hospital policies before it was placed on	S000610	The meatloaf was not served until the internal temperature achieved the appropriate temperature. Kitchen staff number 17 who was alleged to have committed the deficient practice was educated about the proper procedure for serving ground beef immediatley. All staff that prepare and cook food in the kitchen staff will be educated about the	05/17/2013

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	patient trays for serving. Findings included: 1. Kindred Hospital Food Production policy #H-NS 04-013 (last reviewed 6/2011) states, "It is Kindred's policy to prepare and serve food at appropriate temperatures per federal, state, and city food regulations." The policy notes that ground beef internal cooking temperature needs to be 155 degrees Fahrenheit for at least 15 seconds before the ground beef can be served. 2. Kindred Hospital Food Preparation: Minimum Temperatures at Point of Service to Patient policy #H-NS 04-016 (last reviewed 6/2011) indicates the minimum temperature of the food at point of service to the patient (trayline) should be 165 degrees Fahrenheit. 3. Retail Food Establishment Sanitation Requirements, 410 IAC		proper procedure for serving ground beef. Food temperatures are now being logged daily to ensure proper temperatures are met prior to serving. The Food Service Director and the Dietition will be responsible for collecing and reporting the data. 100% compliance with correct food temperatures prior to serving will be expected.	

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	7-24 requires ground beef internal cooking temperature register at a minimum 155 degrees Fahrenheit for at least 15 seconds. 4. At 11:15 AM on 4/15/2013, the kitchen staff were observed cooking 2 ten pound meatloaves that were to be served to the patients in the hospital. Kitchen staff #17 was observed removing a pan of two 10 pound meatloaves from the industrial oven. The staff member checked both meatloaves with an digital thermometer. The staff member was observed sticking the thermometer all the way through the 3-inch thick meatloaf and directly touching the pan. The reading the staff member had was 175 F. The thermometer sensor was on the tip of the thermometer. When the thermometer was placed in the middle of both meatloaves, the temperature readings registered 130 F and 119 F respectively. The meatloaves were placed back in the oven to attain the required temperatures. After approximately			

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	5 minutes in the oven, the staff member removed the pan of meatloaves from the oven and placed one meatloaf on the patient steam table. The staff member sliced one of the meatloaves while displayed on patient serving line. The staff member checked the temperature of one slice of the meatloaf and then placed it on a plate. The plate containing the sliced meatloaf was placed on a patient tray. The sliced meatloaf was pinkish in the middle. The meatloaf was checked for temperature and it was confirmed the meatloaf internal temperature was only 140 F. 5. At 11:45 AM on 4/15/2013, the Food Director confirmed the beef meatloaf was not properly cooked to 155 F internal cooking temperature.			

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S000748	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3) (e) All entries in the medical record shall be: (3) authenticated and dated promptly in accordance with subsection (c)(3). Based on policy and procedure review, medical record review, and interview, the facility failed to ensure the physician orders were authenticated as written or reviewed per policy for 9 of 20 closed in-patient records reviewed (#N9, N10, N11, N12, N13, N15, N16, N18, and N19). Findings included: 1. The facility policy "Transcribing Physician's Orders", last reviewed 10/10, indicated, "Purpose: To accurately transfer the physician's orders properly, thus a member of the healthcare team staff carries out each order. ...4. Each physician's order will be taken off by the Unit Clerk or Nurse. The Respiratory Therapist may take off physician orders related to RT. The Pharmacist may take off physician orders related to medications. 5. As each order is transcribed a check mark to the right of the order is made with the following codes: ...6. All orders transcribed by the Unit Clerks must be checked and signed	S000748	Licensed nursing personnel will be responsible for ensuring that their assigned patients will have all physician orders authenticated as written and reviewed prior to the end of their shift and 12 hour chart checks. To prevent further deficiency, all licensed nursing personnel will be educated on the facility policy and procedure for authenticating physician orders and documentation of required elements in the patient's chart. (5/15/2013) Responsible Parties: Nurse Manager and Nurse Educator Compliance monitoring will be achieved through four weeks of weekday random auditing, followed by weekly random auditing of order verification and 12 hour chart checks by Health Information Manager and Nurse Supervisors. Auditing will be shared with Leadership and Quality Councils on a monthly basis.	05/15/2013

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	by the nurse. When orders are transcribed and/or checked by the nurse, the entire set of orders will be signed off by the nurse drawing a line down the left side of the orders and under the last order, signing his/her full name, date and time of day in red ink." 2. The medical record for patient #N9 indicated a physician order from 12/06/12 that lacked any documentation of nursing transcription or authentication. 3. The medical record for patient #N10 indicated written physician orders and telephone orders from 02/06/13 that lacked any documentation of nursing transcription or authentication. 4 The medical record for patient #N11 indicated a pharmacy protocol written order from 10/25/12 and two printed restraint orders that lacked any documentation of nursing transcription or authentication. 5. The medical record for patient #N12 indicated two telephone orders from 11/16/12 and 12/03/12 and a written physician order from 12/12/12 that lacked any documentation of nursing transcription or authentication. 6. The medical record for patient #N13			

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	indicated a page of written physician admission orders from 02/08/13 that lacked any documentation of nursing transcription or authentication. 7. The medical record for patient #N15 indicated telephone orders from 12/01/12 and a printed sheet of dialysis orders from 12/13/12 that lacked any documentation of nursing transcription or authentication. 8 The medical record for patient #N16 indicated two printed restraint orders and a telephone order from 09/30/12 that lacked any documentation of nursing transcription or authentication. 9 The medical record for patient #N18 indicated a printed sheet of admission orders from 11/14/12 and a pharmacy protocol written order from 11/30/12 that lacked any documentation of nursing transcription or authentication. 10 The medical record for patient #N19 indicated pharmacy protocol written orders from 12/21/12 and 12/31/12 that lacked any documentation of nursing transcription or authentication. 11. At 1:00 PM on 04/17/13, staff member #A3, who navigated the EMR (Electronic Medical Record) confirmed the findings and indicated the orders were			

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	not authenticated by staff according to policy.			

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S000804	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (1) Conduct outcome oriented performance evaluations of its members at least biennially. Based on documentation review and staff interview, the facility failed to ensure the composition of the Medical Executive Committee (MEC) was according the Medical Staff Bylaws. Findings included: 1. Bylaws of the Medical Staff of Kindred Hospital - Indianapolis South (last approved 6/2011) Article IX section 9.4.2 Composition states, "The President of the Medical Staff, Vice President of the Medical Staff, Hospital Medical Director(s) and the	S000804	The Medical Executive Committee will meet to change the language of the Medical Staff Bylaws to reflect that “Thirty-Five percent of the voting members of the MEC must be present to constitute a quorum.” This has been discussed with the Governing Board and will be approved once the Medical Executive Committee meets and makes the motion to change and will go through GB. Medical Executive bylaws are distributed to the Medical Staff and reviewed and voted on monthly to ensure the Medical Staff is compliant with all state, federal, and hospital statues and mandates. The Chief of Staff and Chief Executive Officer of the hospital will ensure compliance ongoing with this regulation.	05/17/2013

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	Medical Staff Secretary-Treasure (if any) always will be voting members of the MEC." Medical Staff Bylaws Article X section 10.2.1-c states, "Fifty percent of the voting members of the MEC must be present to constitute a quorum." 2. The Medical Executive Committee minutes were reviewed April 2012 to February 2013. The committee met 9 times. Eight of the 9 meetings had only 2 voting members while 1 of the 9 meetings only had 1 voting member present. Voting took place for the meeting where 1 voting member was present; therefore, actions took place without a quorum. The meetings evidenced lack of the Vice President of the Medical Staff. 3. At 2:30 PM on 4/16/2013, staff member #2 indicated the Medical Director was actually a group of physicians, Indiana Internal Medicine; however, one physician attends most of those meetings. The staff member indicated the			

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	Medical Executive Committee does not have a Vice President.			

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S000952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (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 (#N2, N3, N4, and N5). Findings included: 1. The facility policy "Transfusion Therapy", last revised 02/2012, indicated, "2. Vital signs (VS) will be observed and documented at minimum ...pretransfusion baseline VS immediately prior to initiation of transfusion, check VS 15 minutes after start of transfusion, check VS at the conclusion of the transfusion, check VS at 1 hour post-transfusion. ...3. Observe patient continuously for signs of transfusion reaction during the first 15 minutes, then every hour during the transfusion." A separate form titled	S000952	The "Blood Transfusion" order set was updated to include nursing actions for one hour observation documentation while blood is infusing and one hour post infusion vital sign documentation. Results will be utilized in the EMR. Nurse Supervisor will be responsible for ensuring that all nursing documentation on blood administration is completed. Documentation in Protouch will include the elements of hourly observation while blood was infusing and one hour post-transfusion vital signs. To prevent further deficiency, all licensed nursing personnel will be educated on the facility policy and procedure for "Blood Transfusion and Administration", documentation of required elements in Protouch and process for notification of Nurse Supervisor when a blood infusion is completed. Responsible Parties: Nurse Manager and Nurse Educator Compliance	05/17/2013

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	"Blood Administration Process", indicated, "8. Blood is documented in ProTouch [electronic medical record system] as required including I&O [intake and output] documentation and vital signs." 2. The medical record for patient #N2, who received a unit of blood on 11/28/12, beginning at 2235 and ending at 0005 on 11/29/12, lacked documentation of an hourly observation at 2345 on 11/28/12. Another unit of blood was started at 0153 on 11/29/12 and ended at 0435 and the record lacked documentation of an hourly observation at 0330 and the 1 hour post-transfusion vital signs. 3. The medical record for patient #N3, who received a unit of blood on 10/26/12, beginning at 0140 and ending at 03455, lacked documentation of an hourly observation at 0255 on 10/26/12. 4. The medical record for patient #N4, who received a unit of blood on 10/07/12, beginning at 0235 and ending at 0450 on 10/07/12, lacked documentation of the 1 hour post-transfusion vital signs Another unit of blood was started at 1650 on 10/07/12 and ended at 1920 and the record lacked documentation of an hourly observation at 1805 and the 1 hour post-transfusion vital signs. On 10/08/12,		monitoring will be achieved through Nurse Manager review of blood administration documentation on 100% of blood transfusion administration in the facility. Auditing will be shared with Leadership and Quality Councils on a monthly basis.	

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	the patient received another unit of blood, beginning at 0240 and ending at 0600 and the record lacked documentation of an hourly observation at 0500 and the 1 hour post-transfusion vital signs. 5. The medical record for patient #N5, who received a unit of blood on 10/26/12, beginning at 0115 and ending at 0245, lacked documentation of the 1 hour post-transfusion vital signs. Another unit of blood was started at 2035 on 11/03/12 and ended at 2350 and the record lacked documentation of hourly observations at 2150 and 2250 On 11/04/12, the patient received another unit of blood, beginning at 0200 and ending at 0416 and the record lacked documentation of an hourly observation at 0315. 6. Upon review of the EMR (electronic medical record) with staff member #A3, any documentation related to the hourly observations was not noted as such, but were coincidental times that the nurse charted on the patient for some reason. Staff member #A3 confirmed it could not really be determined how the hourly observations were to be documented to adhere to policy.			

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S000954	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e) (e) Emergency equipment and emergency drugs shall be available for use on all nursing units. Based on policy review, facility document review, and interview, the facility failed to perform checks of emergency equipment and supplies on 3 of 3 patient units. Findings included: 1. The facility policy "Hospital Wide Plan for Resuscitative Services", last reviewed 10/10, indicated, "5. Each Code Cart will be checked by the Nursing Patient Care Coordinator or designee and the Respiratory PCC/Charge or designee twice per day or once per shift. These checks will include the following: a. Check the presence and integrity of the cart and check the appropriate column. ...d. The Nursing PCC and RT PCC will sign in the appropriate column to document that the code cart check has been completed. ...f. Pharmacy will check the code cart monthly to maintain current medication dates." 2. Review of the "Emergency Equipment Surveillance" logs for the first quarter of 2013 indicated the following:	S000954	Nurse Supervisor/Respiratory Therapy Supervisor will be responsible for completing twice daily checks of the defibrillator carts. To ensure compliance, the oncoming Nurse Supervisor will verify that the check has been completed prior to the end of each previous scheduled shift. (5/2/2013) To prevent further deficiency, all Nurse Supervisors, nursing personnel and Respiratory Therapy Supervisors will be educated on the facility policy “Resuscitative Service Plan” and documentation of required elements.Responsible Parties: CCO, Nurse Manager and Nurse Educator Compliance monitoring will be achieved through Nurse Manager auditing of defibrillator check-off sheets on a weekly basis and will be shared with Leadership and Quality Councils on a monthly basis.	05/17/2013

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	A. Cart #2- Nursing documentation of checks missing for 4 days and 6 nights in January, 2 days and 11 nights in February, and 2 days and 8 nights in March. Respiratory checks missing for 7 days in February and 8 days in March and no night documentation at all for January, February, or March. B. Cart #4- Nursing documentation of checks missing for 5 days and 8 nights in January, 8 days and 10 nights in February, and 1 day and 7 nights in March. Respiratory checks missing for 2 days in February and 7 days in March and no night documentation at all for January, February, or March. C. Cart #5- Nursing documentation of checks missing for 8 days and 24 nights in January, 3 days and 4 nights in February, and 5 days and 8 nights in March. Respiratory checks missing for 7 days in February and 4 days in March and no night documentation at all for January, February, or March. 3. Discussion with staff members #A1 and A3 at 11:30 AM on 04/16/13 confirmed the findings and indicated there was probably some miscommunication with the respiratory department regarding the checks. Both staff members indicated another part of the problem could be that the carts rotated and did not stay on one specific unit. The directions on the form			

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(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
	also were not followed as far as indicating monthly checks for outdates had been completed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	04/17/2013

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S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on document review, observation and staff interview, 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 are assured in two (2) instances: Kitchen Dry Storage and Housekeeping Storage Closet. Findings included: 1. Kindred Hospital Safety and Security Management Plan policy #EC.01.01.01.03 & 04 (last approved 1/13) requires the hospital to meet OSHA, federal, state, and local rules and to	S001118	The canisters that were delivered prior to the surveyor's inspection of the kitchen were immediately chained upon noticing the deficient practice. The food service director had a conversation with the company delivering the CO2 and instructed them that they cannot deliver the canisters without notifying kitchen staff. Kitchen staff will be educated on the proper procedure to secure the canisters. The Director of Food Service will be responsible to ensure the deficient practice does not recur. An eye-wash station will be installed in the room with the two green industrial floor scrubbers. Gloves and eye protection will be purchased and supplied for staff that will use the floor scrubbers. All environmental services staff will be educated to the location of the eye wash station and the proper procedure to use the eye wash station by	05/17/2013

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	promote safety in the workplace by eliminating hazards as they are discovered. 2. At 11:00 AM on 4/15/2013, four of four C02 cylinders were not secured in the kitchen Dry Storage Room. The chain was observed hanging from the racks and not around the cylinder to protect staff and visitors from them falling over. 3. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach		May 17, 2013. All environmental services staff will also be educated about location and use of gloves and eye protection when using the industrial walk behind scrubbers. The Director of Environmental Services will be responsible to ensure the deficient practice does not recur.	

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	but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard." 4. The Tennant Automatic Scrubber has warning requirements. The scrubber's operating manual notes that the batteries emit Hydrogen Gas and staff are to wear protective gloves and eye protection 5. At 1:15 PM on 4/16/2013, the housekeeping storeroom was toured. One of two Green industrial walk-behind floor scrubbers was observed plugged into a 12-volt battery charger. The floor scrubbers contains 12-volt batteries that contain corrosive acid. The room did not have an eye-wash station for safety of staff when they are handling the batteries.			

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S001164	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 documentation review, the facility failed to maintain the operating temperature as recommended by the Hydrocollator Mobile Heating Unit's user manual. Findings included: 1. The Rehab Department's Hydrocollator Mobile Heating Unit user manual states, "The recommended operating temperature is 160 F to 166 F." 2. The Rehab Department's Hydrocollator Temperature log states, "Acceptable Temperature Range: 165 - 177 degrees." The ranges recorded on the April 2013	S001164	UHS was notified and responded to a requested service call on 4/22/2013. The hydorcollator temperature control unit was reset to the manufactures recommended settings. The temperature then settled to within the recommended settings. The hydrocollator is currently monitored daily during operational business hours and reported through Clinical Services and Quality Council.The Rehabilitation Manager and the CCO are responsible for collecting and reporting the data.	04/22/2013

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	log were between 168 F to 171 F.			