STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150176	A. BUILDING 00 B. WING	09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKIANA MEDICAL CENTER LLC	4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129

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S 0000 Bldg. 00	This visit was for the State investigation of a hospital complaint. Complaint #IN00174445 Substantiated: State deficiencies related to the allegations are cited; State deficiencies unrelated to the allegations are cited. Date of survey: 9/9/15 Facility number: 011788 QA: cjl 09/22/15	S 0000		
S 0322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the chief executive office failed to ensure their policy & procedure	S 0322	KMC Policy PR 109 was reviewed and approved by the Board of Mangers at their quarterly meeting 9-30-15 Copy attached:	10/23/2015

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

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	(P&P) for patient grievances was followed for 1 of 3 greivances reviewed (C#1). Findings: 1. Review of the P&P titled Patient Grievances, Document Number: PR 1.09, indicated the following: 3. If a patient, family, or visitor voices a concern, complaint or grievance, the Privacy Contact Person will initiate a Patient Complaint Form and then forward the form immediately to the Chief Operating Officer (COO). 4. The Center will make every attempt to complete or resolve a grievance within 7 days, the Center will inform the patient and/or representative or visitor in writing that the hospital is still attempting to resolve the grievance and they will receive written notice of resolution with 30 days. 5. In the resolution of the grievance, the Center will provide the patient, family or visitor with a written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion. The P&P was last updated 9/10/12. 2. Review of facility complaint/grievance documentation		Plan of Action: All staff will be reminded of policy requirements and required actions to be taken at annual training and each new employee orientation. In order to get the information out quickly, the policy will be discussed at the Department Head Meeting 10-23-15 for further dissemination to the staff immediately. Monitoring will be accomplished by the CNO reviewing daily the shift report prepared by the House Supervisor for any incident of patient or family complaint, as well as any and all incident reports not included in the shift reports turned into the CNO. Responsible: The Chief Operating Officer is responsible for compliance of this standard	

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	between 3/1/15 to 9/9/15 indicated a complaint was voiced on 4/28/15 by a patient's family member (C#1) and was documented on a complaint form. The documentation indicated C#1 requested a report of the complaint be made and was agreed to by A1 Chief Operating Officer (COO). The documents indicated a follow up letter was prepared for the complainant on 6/11/15 by A8, Chief Financial Officer (CFO). 3. On 9/9/15 at 4:15pm, A8, CFO, indicated that approximately a week and a half prior to 5/18/15, he/she overheard C#1 complaining in a heated tone to the front desk receptionist and intervened. A8 indicated that C#1 voiced concern about a physician not helping his/her family member and that he/she had not yet received a report of the investigation as promised. A8 indicated he/she agreed to look into the matter. A8 indicated that C#1 phoned the hospital on 5/18/15, 5/19/15, & 5/20/15 requesting follow up information. A8 indicated that on 6/7/15 he/she agreed to write the follow up report and on 6/9/15 attempted to contact C#1 for a mailing address. A8 indicated the letter was sent to C#1 on approximately 6/22/15. 4. Review of phone log documentation indicated C#1 phoned the hospital			

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	5/18/15 and left a message for A8; phoned 5/19/15 and left a message for A1; phoned 5/20/15 and left a message again for A1.			
S 0712 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(1) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information. Based on document review and interview, the hospital failed to maintain adequate documentation of services rendered for 1 of 4 patients (P#1). Findings: 1. Review of the Policy & Procedure (P&P) titled Authorization for Medical/Surgical Treatment and/or Procedure; Document Number: NSG 2.06, indicated the following: In the event of an emergency, a physician documents the necessity of the emergency procedure, done without	S 0712	KMC Policy NSG 2.06 was reviewed and approved by the Board of Managers. Copy attached: Plan of Correction: Medical records will be completed by physicians and other licensed professionals when performing an emergency procedure. The Quality committee will review all emergency procedure documentation for completeness and accuracy. The policy will be reviewed at annual training as well as new employee orientation. The policy will be reviewed at the Department Head meeting Friday, 10-23-15 for immediate dissemination to staff. Monitoring will be accomplished	10/23/2015

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	written consent, on the Medical Record. The P&P was approved 9/11/12. 2. Review of patient #1's medical record (MR) indicated, in the Progress Note dated 4/28/15 at 0908, that the patient was intubated on 4/27/15. Further MR documentation indicated the patient was placed on a mechanical ventilation system following the intubation. The MR lacked documentation of the intubation procedure or the necessity of the procedure. 3. On 9/9/15 at 12:30pm A6, Informatics Manager, indicated the MR lacked documentation of the intubation procedure and necessity. 4. On 9/9/15 at 12:45pm, A7, Respiratory Therapy Manager, indicated the MR lacked documentation of the endotracheal tube placement necessity.		by review of the daily shift report prepared by the House Supervisor by the CNO. Each emergency procedure will be reviewed weekly by CNO for compliance. Responsible: The Chief Nursing Officer will be responsible for compliance of this standard.	
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:			

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	(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on document review and interview, the nurse executive failed to ensure facility policies & procedures (P&P) was followed for 3 of 4 patients (P#1, P#3 & P#4). Findings: 1. Review of the P&P titled Transfer of Patients Internally; Document Number: NSG 8/02, indicated the following: Nurse will call the receiving unit and give a status/condition report on the patient. Receiving nurse will document	S 0912	KMC Policies NSG 6.11 and NSG 8.02 were reviewed and approved by the Board of Managers at their quarterly meeting 9-30-15. Copies attached. Plan of action: 1) Nurses have been trained on the requirements to document in the EMR all transfers within as well as outside of the facility. Re-education is being currently accomplished with a completion date of 11-6-15. Nurses will complete a nurse's note/communication note when a patient is transferred from one nursing unit to another unit Monitoring patient transfers will	11/06/2015

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	receipt of patient and their status in the medical record (MR). The P&P was approved 9/11/12. 2. The P&P titled Code Blue/Medical Emergencies; document Number: NSG 6.11, indicated the following: Critical Care Nurse will: Maintain an accurate record of all activities on cardio-pulmonary Resuscitation Sheet...Provide for the disposition of patient at the termination of the code blue. The P&P was approved 9/11/12. 3. Review of the procedure document titled Nursing Assistant Roles and Responsibilities indicated, under the hygiene section, Bath given (Bed bath, shower) - (every 24 hours and PRN [as needed]). 4. Review of the MR for patient #1 indicated the following: A. The patient was an inpatient of the hospital between 4/22/15 and 5/18/15. The MR indicated the patient was transferred to the intensive care unit (ICU) on 4/27/15 following intubation and implementation of mechanical ventilation. The record lacked documentation of a nurse giving a status/condition report on the patient or receipt of the patient by the receiving nurse.		occur by auditing EMR documentation daily to ensure accuracy. A patient transfer log will also be kept at each unit secretary desk. Department Directors are responsible for ensuring his/her staff are compliant. the CNO will also perform random EMR audits to ensure compliance. All nursing personnel received communication via e-mail discussing this requirement by 11/1/15. Responsible: The Chief Nursing Officer is responsible for compliance of this standard 2) In-service with House Supervisors and Directors were completed on 11/18/15 regarding correct documentation of Code Blue forms. Documentation review of Code Blue/Emergency situations will occur after each episode by the House Supervisor on duty on an on-going basis. The House Supervisor is present for all Code/Blue/Emergency situations and is responsible for ensuring documentation is complete. The House Supervisor will review all areas of the Code Blue form for completeness and correct any missing documentation before the end of the shift. The CNO will also receive a copy of each Code Blue/Emergency situation for review to ensure completeness and accuracy of the record following each occurrence. The records will be reviewed by the Quality committee for	

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	B. The MR indicated the patient the patient was provided hygiene, but lacked documentation of a bath being given between 4/26/15 at 0900 hrs and 4/29/15 at 0200 hrs, between 4/30/15 at 1400 hrs and 5/2/15 at 1000 hrs, between 5/7/15 at 1600 hrs and 5/10/15 at 1000 hrs, between 5/16/15 at 1500 hrs and 5/18/15 at 1000 hrs 5. Review of the MR for patient #3 indicated the patient was an inpatient of the hospital from 5/2/15 to 5/6/15. The MR included 2 Cardio-Pulmonary Resuscitation (CPR) sheets as follows: One indicated Time Code Blue Called: 1440 hrs and included a note of patient transfer to ICU. The document lacked documentation of a date. The other CPR sheet, dated 5/6/15, lacked documentation of time Code Blue Called, but did indicate Time Code Ended by M.D. as 1932 hrs. The Resuscitation Sheet lacked documentation of disposition of the patient at termination of the code blue. The Discharge Summary of the MR indicated the patient expired on 5/6/15. The MR included a Death Record indicating the patient expired 5/6/15 at 1932hrs. 6. Review of patient #4's MR indicated the 73 year old was admitted 5/6/15 after presenting in the ED with a complaint of		completeness quarterly. Forms attached: Responsible: The Chief Nursing Officer is responsible for compliance of this standard 3) Daily bathing documentation audits will be completed to ensure compliance with documentation of independent/self-bathing, bath with assist, complete bed bath, and refusal of bath. Discrepancies will be addressed on a 1:1 basis with employees not compliant with documentation. Department Directors will review audits on a monthly basis beginning with October 31, 2015 audits and are responsible to ensure compliance in their area. the CNO will also perform random chart audits to ensure compliance with this requirements. Responsible: The Chief Nursing officer is responsible for compliance 4) (a) Medical Records will include documentation of transferring of patients both inside and outside of the facility as indicated by above procedures and monitoring for completeness.. Responsible: The appropriate Department Head is responsible for this action with the Chief Nursing Officer responsible for compliance 4) (b) Hygiene care including baths will be documented daily Nursing service is being re-educated to perform these requirements daily as indicated by above procedures and monitoring for completeness. Responsible: The appropriate Department Head is responsible	

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	chest pain and a fall and was discharged on 5/11/15. The MR lacked documentation of a bath being given on 5/7/15 or 5/8/15. 7. On 9/9/15 at 3:45pm, A6, Informatics Manager, indicated the MR for P#1 lacked documentation of the ICU transfer per P&P and that the patient appeared to have received hygiene throughout stay, but did have periods without a full bath. A6 also indicated the MR for P#3 lacked appropriate documentation per P&P of the CPR sheets and that the MR for P#4 lacked documentation of a bath being given at least every 24 hours. A6 indicated the facility P&P is that all patients are bathed at least every 24 hours.		for this action with the Chief Nursing Officer responsible for compliance 5) Code Blue/Emergency forms will be reviewed by supervisor and Chief Nursing Officer to ensure accuracy and completeness after each occurrence as indicated by above procedures and monitoring. Responsible: The appropriate Department Head will be responsible for this action with the Chief Nursing Officer responsible for compliance of standard 6) Hygiene care including baths will be documented daily. The nursing staff has been re-educated to perform these actions and document appropriately as indicated by above procedures and monitoring. Responsible: The appropriate Department is responsible for these action with the Chief Nursing Officer responsible for compliance of standard 7) Nursing service has been re-educated on the requirements to document transfers within or outside of the facility to include a status/condition report on the patient as indicated by above procedures and monitoring. Responsible: The appropriate Department Head is responsible for these actions with the Chief Nursing Officer responsible for compliance.	