STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152018	A. BUILDING 00 B. WING	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHERN INDIANA	215 W 4TH ST STE 200 MISHAWAKA, IN 46544

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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 5/9/2016 to 5/10/2016 Facility Number: 002605 QA:	S 0000		
S 0296 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (c)(2) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (2) Appoint a qualified chief executive officer who is delegated the authority and responsibility for managing the hospital and report to the division the name of the chief executive officer within ten (10) days after the appointment. Based on interview, the hospital failed to report to the Indiana State Department of Health (ISDH) within ten (10) days the appointment of the Chief Executive Officer (CEO). Findings include;	S 0296	Immediate Action Taken: On 5/11/16, each member ofthe hospital's leadership team including members of the Governing Board, aswell as, the Administrative Assistant were re-educated on 410 IAC 15-1.4-1 thatrequires the hospital to report to the division the name of the chief executiveofficer within 10	05/19/2016

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

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	At 10:33 a.m. on 5/11/16, staff member #2 (CEO) indicated he/she was appointed as CEO on July 15, 2014. The staff member confirmed that ISDH was never notified of the change in CEO.		days of the appointment. Corrective Action Taken forS 296 A letter was drafted on5/19/16 and sent to Mr. John Lee, Nurse Surveyor Supervisor, Program DirectorHospitals with ISDH on this same date. On 6/1/16, it was confirmedwith Terrance Dillon, Kindred Healthcare's Manager of Licensure andCertification that on 8/11/14, the change in Chief Executive Officer wassubmitted electronically to CMS/Medicare through the pecos.cms.hhs.gov site viathe electronic 855 update database by It was confirmed on 5/19/16 that afterthe electronic notification, the correspondence from CMS and WisconsinPhysician Services was to the attention of Lori Skora. Responsible party: ChiefExecutive Officer Completion date: 5/19/16	
S 0598 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv) (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:			

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	(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: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation, documentation review, and interview, the hospital failed to ensure the blanket warmer complied with Perioperative Standards and Recommended Practices (AORN) for warming temperature requirements. Findings included: 1. At 12:05 PM on 5/10/2016, the Medical/Surge Nursing Unit's storage room was observed with a table-top blanket warmer that read 200 degrees Fahrenheit. 2. In review of the Infection Prevention and Control Program which stated, "Plans, risk assessment and policies and procedures are based on Centers for Disease Control (CDC), Perioperative Standards and Recommended Practices (AORN), Occupation Safety and Health Administration (OSHA), and Centers fort Medicare and Medicaid Services (CMS), Joint Commission Requirements, and Indiana State Department of Health (ISDH)." The policy was last approved	S 0598	Immediate Action Taken: On 5/11/16, signage wasposted on the Blanket Warming unit to indicate that the temperature was not toexceed 125 degrees Fahrenheit Responsible Person: ChiefClinical Officer Corrective action for S 598findings 1 -4 Process Implemented: On 6/1/16, the ChiefClinical Officer drafted at policy titled Blanket Warmer Maintenance andMonitoring, as well as, a temperature monitoring log to monitor dailytemperatures of the unit. The temperature of the cabinet will be set to 125 degreesF (Fahrenheit), as to not exceed 130 degrees F. The Blanket Warmer policy willbe reviewed and approved at Patient Safety and Reliability Committee on6/27/16, Quality Council on 6/27/16, and Medical Executive Committee on 7/6/16.All clinical staff that would have access to the blanket warmer will completeeducation on the newly developed policy and temperature	07/31/2016

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	8/24/2015. 3. In review of AORN guidelines for blanket warming which stated, "Warming cabinet or compartment temperatures used for blankets and other patient linens should not exceed 130 Fahrenheit. This recommendation is based on stronger evidence that shows temperatures greater that 130 degrees Fahrenheit increase the potential for burns." 4. In interview at 12:15 PM on 5/10/2016, staff member #3 (Quality Director) confirmed all the above and no other documentation was provided prior to exit.		monitoring requirementsby 7/31/16 Monitoring: To ensure temperatures areappropriately set, weekly audits of the temperature monitoring log will becompleted by the Chief Clinical Officer. The blanket warmertemperature audits will be included in the CCO checklist and reviewed at thequarterly Patient Safety and Reliability meetings, Quality Council andGoverning Board Meetings. Next meeting is scheduled for 7/25/16. Responsible Person: ChiefClinical Officer (CCO) Completiondate: 7/31/16	
S 0610 Bldg. 00	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			

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	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 document review, observation and interview, the hospital failed to ensure a container of milk was date marked after it was opened. Findings included: 1. Review of Nourishment Rooms/Pantries Safety & Sanitation policy last reviewed/revised 5/15 indicated "Patient food storage areas (i.e. nourishment rooms, pantries, kitchenettes) are governed by food codes and regulations to minimize the risk of food-borne illness and ensure a sanitary environment." 2. Review of Indiana Administrative	S 0610	Immediate Action Taken: On 5/16/16, three Kindred policies that related to Food andNutrition Services were reviewed by the Director of Quality Management and theRegistered Dietician: Food Supply and Storage, Nourishment Rooms / PantriesSafety and Sanitation, and Food Brought by Visitors. Responsible Person: ChiefClinical Officer Corrective Action for S 610 Findings 1 -4 Process Implemented: On 6/10/16, a document wasdeveloped to educate all bedside clinical staff that have access to thenourishment rooms. The document identifies key elements around food storage andlabeling to include: any food container that is opened must be labeled with anopen date and an use by date. Food brought from home by	07/20/2016

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	Code, 410 IAC 7-24-191, indicated, "Refrigerated, ready-to-eat potentially hazardous food shall be clearly marked, at the time the original container is opened and discarded within 7 cumulative refrigerated storage days. The day or date marked may not exceed a manufacturer's use-by date." 3. At 11:45 AM on 5/10/2016, the Med/surg Nursing Unit Nutritional Pantry's patient refrigerator was observed with a half filled opened 1/2 gallon container of milk without any date on the container reflecting the date it was opened or date it will be discarded after having been opened. 4. Interview at 11:50 AM on 5/10/2016, staff #3 (Director Quality Manager) confirmed all the above and no other documentation was provided prior to exit.		visitors for patientsshould have the patient's name, a received, a discard date that is not morethan 3 days after it was received. Under the direction of the Chief ClinicalOfficer, the Registered Dietician will complete education with all staff by7/20/16. Monitoring: The Registered Dietician will complete audits in each of the nourishment rooms weekly and complete theNourishment Room Audit tool and the Food and Nutrition Services Labeling /Dating Audit tool. The Nourishment Room audits will be included in the CCOchecklist and reviewed at the quarterly Patient Safety and Reliability meetings,Quality Council and Governing Board Meetings. Next meeting is scheduled for7/25/16. Responsible party: ChiefClinical Officer Completion date: 7/20/16	
S 1118 Bldg. 00	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			

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	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 observation, document review, and interview, the hospital failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff was assured in two (2) instances in the Boiler Maintenance Room and for one (1) blanket warmer on the medical/surgical unit. Findings included: 1. At 11:15 AM on 5/10/2016, the Boiler Maintenance Room was observed with two of the three boilers in operation. Neither of the two boilers were observed with a Boiler Certificate inspection posted near the boilers. 2. The two Boiler Certificate of Inspection reports, located in the maintenance office stated, "This certificate of Inspection must be posted under glass in the room the vessel is located." Boiler certificate #1 expiration date was 11/12/2015 and boiler certificate #2 expiration date was 8/26/2016. The two certificates were not	S 1118	Immediate Action Taken: On 5/10/16, Saint JosephRegional Medical Center's Facility Resources Director, Greg Kozlik, was notifiedof needed corrections in the boiler maintenance room. Responsible Person:Director of Quality Completion date: 5/10/16 Corrective Action Taken forS 1118 for Findings 1 -5 Boiler Maintenance Room - boiler certificates: KindredHospital Northern Indiana leases space on the first, second, and third floorsfrom Saint Joseph Regional Medical Center in a building located at 215 WestFourth Street. Saint Joseph Regional Medical Center (SJRMC) maintains theboiler systems as well as the boiler maintenance room that is not connected to,but adjacent to the leased space. As of 5/11/16, boiler #1 (017835) has aCertificate of Inspection that is posted in the same room as the vessel withand expiration date of 8/26/16. Boiler #2 (017836) has a Certificate of Inspectionthat is	05/13/2016

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	posted in the room with the two boilers and 1 of the two certificates of inspections was expired. 3. At 11:30 AM on 5/10/2016, the Boiler Maintenance room chemical closet was observed with an eyewash station. The eyewash inspection log attached to the device indicated 12/7/09 was the last weekly inspection that was performed on the eyewash station. 4. In review of Eyewash Use, Inspection and Maintenance policy which stated, "Eyewashes and drench hoses shall be activated weekly for at least three minutes. Activation, performance and cleaning must be documented using the eyewash inspection log." The policy was last approved 8/24/15. 5. Interview at 12:15 PM on 5/10/2016, staff member #6 (Maintenance Staff) confirmed all the above and no other documentation was provided prior to exit. 6. Review of the Infection Prevention and Control Program indicated, "Plans, risk assessment and policies and procedures are based ...Perioperative Standards and Recommended Practices (AORN)...." The policy was last approved 8/24/2015.		posted in the same room as the vessel with an expiration date of10/1/16. The property managers,Saint Joseph Regional Medical Center, have added a weekly maintenance log forthe emergency eye wash station in the boiler maintenance building adjacent tothe hospital. Checks that include activation and inspection of the eye washstation have been occurring weekly as of 5/13/16. Process Implemented; The boiler maintenanceroom will be added to the Environment of Care rounds to be completed by theDirector of Quality in August and October to verify Certificates of Inspectionsare current and posted as stated. The verification of currentCertificates of Inspections for the boilers will also be added to the ChiefExecutive Officer's checklist that is completed in June and December of eachyear, with results reviewed at quarterly Leadership Committee Meetings, as wellas, Quality Council meetings. Monitoring: Kindred Hospital NorthernIndiana will add the review of eye wash station inspection logs in the boilermaintenance room to the items on the CEO Checklist that is completed in Juneand December of each year, with the results to be shared the quarterlyLeadership Committee	

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	7. Review of AORN guidelines for blanket warming indicated, "Warming cabinet or compartment temperatures used for blankets and other patient linens should not exceed 130 Fahrenheit. This recommendation is based on stronger evidence that shows temperatures greater that 130 degrees Fahrenheit increase the potential for burns." 8. At 12:05 PM on 5/10/2016, the Medical/Surgical Nursing Unit's storage room was observed with a table-top blanket warmer that read 200 degrees Fahrenheit. 9. Interview at 12:15 PM on 5/10/2016, staff member #3 (Quality Director) confirmed all the above and no other documentation was provided prior to exit.		meetings, Quality Council and Governing Board Meetings.Next meeting is scheduled for 7/25/16. Responsible Person: ChiefExecutive Officer Completion date: 5/13/16 Immediate Action Taken: On 5/11/16, signage wasposted on the Blanket Warming unit to indicate that the temperature was not toexceed 125 degrees Fahrenheit Responsible Person: ChiefClinical Officer Corrective action for S1118 findings 6 -9 Process Implemented: On 6/1/16, the ChiefClinical Officer drafted at policy titled Blanket Warmer Maintenance andMonitoring, as well as, a temperature monitoring log to monitor dailytemperatures of the unit. The temperature of the cabinet will be set to 125degrees F (Fahrenheit), as to not exceed 130 degrees F. The Blanket Warmerpolicy will be reviewed and approved at Patient Safety and ReliabilityCommittee on 6/27/16, Quality Council on 6/27/16, and Medical ExecutiveCommittee on 7/6/16. All clinical staff that would have access to the blanketwarmer will complete education on the newly developed policy and temperaturemonitoring requirements by 7/31/16 Monitoring: To ensure temperatures areappropriately set, weekly audits of the temperature	

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			monitoring log will becompleted by the Chief Clinical Officer. The blanket warmertemperature audits will be included in the CCO checklist and reviewed at thequarterly Patient Safety and Reliability, Quality Council and Governing Boardmeetings. Next meeting is scheduled for 7/25/16. Responsible Person: ChiefClinical Officer Completion date: 7/31/16	
S 1160 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on document review and interview, the hospital failed to have evidence of annual preventive maintenance on the automatic floor scrubbers as required by the manufacturer. Findings include: 1. Review of Clarke Floor Scrubber operation's manual indicated the machine should have an annual preventive maintenance inspection performed by a Clarke authorized service center.	S 1160	Immediate Action Taken: On 5/16/16, theEnvironmental Services (EVS) Manager for Kindred Hospital Northern Indiana wasable to secure Harter Floor Care Supply out of Elkhart, Indiana to performpreventative maintenance on the Clarke Focus II Boost floor scrubber (S/N8000086552). Responsible Person: EVSManager Completion Date: 5/16/16 Corrective Action for S1160 findings 1 - 3 Process implemented; TheEVS	06/17/2016

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	2. Review of the hospital preventive maintenance inspection reports indicated the hospital lacked annual preventive maintenance inspections on the floor scrubber. 3. Interview at 1:30 PM on 5/10/2016, staff member #5 (Environment Service Manager) confirmed all the above and no other documentation was provided prior to exit.		Manager has developed a preventative maintenance tracking log for allequipment and will be responsible for oversight of compliance with maintenanceschedules. Harter Floor Care Supply was on site on 6/17/16 to complete annualpreventative maintenance per Clarke recommendations. Harter Floor Care Supplywill continue provide annual preventative maintenance and repairs necessarythat are beyond user level functions. Monitoring:Compliance with preventative maintenance will be monitored via the CEOChecklist completed in June/December or each year and reported to quarterlyLeadership Committee Meetings, as well as, quarterly Quality Council andGoverning Board Meetings. Responsible party:Environmental Services Manager Completiondate: 6/17/16	
S 1164 Bldg. 00	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:			

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	(B) There shall be evidence of preventive maintenance on all equipment. Based on document review, observation, and interview, the hospital failed to ensure 14 pieces of patient care equipment had preventive maintenance inspections conducted on them. Findings included: 1. Review of Medical Equipment Management Plan (MEMP) which stated, "Kindred facilities provide a safe environment for its patients, visitors, and staff by managing, maintaining, testing and inspecting all medical equipment (biomedical equipment) before initial use and throughout the life of the equipment." The MEMP was last approved 8/24/2015. 2. Review of the biomedical equipment preventive maintenance logs indicated there were no wheelchairs nor patient walkers noted in the preventive maintenance logs. 3. At 9:30 AM on 5/10/2016, the Rehabilitation In-patient department storage room was observed with 12 wheelchairs and 2 blue walkers.	S 1164	Immediate Action Taken: On 5/10/16, the Director ofRehabilitation Services completed an inventory list of all hospital ownedwheelchairs and walkers. Responsible Person:Director of Rehabilitation Services (DRS) Completion Date: 5/10/16 Corrective Action Taken forS 1164 findings 1 - 4 Process Implemented: On 6/10/16, the DRSdeveloped a preventative maintenance (PM) checklist for the hospital'swheelchairs and walkers. On 6/21/16, the PM checklist was completed on theinventory of wheelchairs and walkers by the Rehabilitation Services Departmentunder the direction of the Director of Rehabilitation Services. Monitoring: After this initialinspection, the preventative maintenance will occur twice a year at 6 monthintervals (April / October) the completion of the every six month PMs will be reviewed aspart of the CCO checklist that is completed in May and November each year, withresults reviewed at the quarterly Patient Safety and	06/21/2016

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	4. At 9:45 AM on 5/10/2016, staff member #10 (Rehab Manager) confirmed all the above and no other documentation was provided prior to exit.		Reliability Committee,Quality Council and Governing board. Next meeting is scheduled for 7/25/16. Responsible party:Environmental Services Manager Completiondate: 6/21/16	