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	11/18/2014

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KENTUCKIANA MEDICAL CENTER LLC	4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129

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S000000	This visit was for a standard State licensure survey. Facility Number: 011788 Survey Dates: 11/17/14 to 11/18/14 Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor Ken Ziegler, MT, MS Medical Surveyor III Nancy Otten, RN Public Health Nurse Surveyor QA: claughlin 01/15/15	S000000		
S000312	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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:			

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

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	(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the facility failed to maintain personnel records for each employee of the hospital which included annual performance evaluations for 9 (nine) of 15 (fifteen) personnel files reviewed. Findings include: 1. Review of staff #1, #3, #4, #5, #6, #9, #10, #13, and #14's personnel files indicated lack of evidence of any yearly performance review. All had worked at the facility for over one year. 2. On 11/18/2014 at 1130 hours, staff member #7, Human Resources Manager, indicated that the hospital does do yearly evaluations per hospital "unwritten policy", and agreed staff #1, #3, #4, #5, #6, #9, #10, #13, and #14's personnel files lacked of evidence of any yearly performance review.	S000312	Human Resources has provided each Director as well as each Department Head a list of the tardy personnel evaluations. These evaluations are to be completed prior to 3-15-15.Director of Human Resources is responsible for this effort.Chief Nursing Officer and Chief Operating have overall responsibility to see this is completed.A list of required evaluations broken down by month has been provided for the remainder of 2015 to each Director and Department Head. The Director of Human Resources is task to provide the Chief Operating Officer a monthly report on the delinquent evaluations and the Chief Operating Officer is responsible for completion.	03/15/2015

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S000318	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F) (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: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the facility failed to ensure current CPR (Cardio-Pulmonary Resusitation) or ACLS (Advanced	S000318	CPR and ACLS classes have been scheduled for 2015. Employees will be required to attend one of the scheduled classes or be responsible to	03/11/2015

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	Cardiac Life Support) competency for 4 (four) of 15 (fifteen) nursing personnel files reviewed, as required by hospital policy. Findings included: 1. Based on Hospital Policy HR 1.06, dated 09/04/2012, 7. stated "CPR certification will be maintained by Hospital Administration. All clinical employees will be required to have current CPR certificates on file." 2. Personnel files of staff members #7, #9, #12, and #13 lacked current CPR or ACLS certificates. 3. Staff member #7, Human Resources Manager, agreed with these findings on 11/18/2014 at 1300 hours.		attend a class outside of Kentuckiana Medical Center before the expiration of their certification. Please see schedule attached.No employee will be scheduled to work until certification is obtained.Director of Human Resources is responsible to obtain copies of all certifications and provide a list of upcoming needs to the Chief Nursing Officer so she can ensure the staff members complete the requirements. Chief Nursing Officer will monitor the report from The Director of Human Resources to ensure complete compliance and have overall responsibility to prevent any employee from working without proper certification.	
S000330	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (c) The governing board is responsible for managing the hospital. The governing board shall do the			

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	following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. **Based on facility document reviews and staff interview, the hospital failed to document a personnel record for one (consulting dietitian) of eleven personnel employed by the facility and failed to ensure infectious disease status for 2 of 15 personnel files reviewed (#9, #12).** **Findings included:** **1. In interview on 11/18/14 at 11:00 a.m., employee #1 acknowledged the hospital had no documentation indicating one personnel record (consulting dietitian) was available for review.** 2. Hospital policy IC 1.02, dated 9/4/2012, stated "The Infection	S000330	1 The license and contract for the staff dietitian is attached as well as documentation of her weekly evaluations. 2. Nursing personnel files have been reviewed and updated to reflect current PPD (Purified Protein Derivative). Human Resources is task to provide a list with due dates of all Directors and Department Heads by 2-27-15 of the annual requirements for their staff. This report will be provided annually and monitored by the QUAPI Committee. Department Heads are responsible for compliance of their staff with the Chief Nursing Officer and the Chief Operating Officer for compliance of the overall program.	02/27/2015

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	Prevention and Infection Control is an active program for the prevention, control and investigation of infections and communicable diseases. Activities include: 17.: Monitoring employee health in regards to infectious disease...." 3. Review of nursing personnel files #9 and #12 indicated lack of current PPD (Purified Protein Derivative) or chest x-ray testing to prove immunity to TB. 4. Staff member #7, Human Resources Manager, on 11/18/2014 at 1315 hours agreed with these findings.			
S000392	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(2) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (2) That the services performed under a contract are provided in a safe and effective manner and are included in the hospital's quality assessment and improvement program. Based on document review and interview, the hospital governing board (GB) failed to ensure services performed	S000392	Contracted services, such as Biomed engineering, blood bank, housekeeping, tele-radiology and security will become part of the	02/27/2015

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	under contract were included in the quality assurance and performance improvement (QAPI) program in five of ten (5 of 10) instances (biomedical engineering, blood bank, housekeeping, tele-radiology, and security). Findings: 1. Review of QAPI meeting minutes and reports dated 10/24/13, 1/23/14, 3/22/14, 6/24/14 and 9/26/14 indicated lack of evidence of quality assurance activity for the following contracted services: biomedical engineering, blood bank, housekeeping, tele-radiology, and security. 2. In interview on 11/18/14 at 3:30pm, A2, chief nursing officer/QAPI manager, confirmed the above were contracted services and had not been included in QAPI program.		QUAPI plan reporting quarterly to the committee. See the monthly department reporting schedule attached.The Chief Operating Officer is responsible for ensuring the reports are submitted to QUAPI.The Chief Nursing Officer is responsible for reporting through QUAPI committee to the Board of Managers.	
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			

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	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 interview, the quality assessment and performance improvement program (QAPI) failed to include all areas of the hospital and all contracted services in the program for 14 of 31 directly provided services/functions (cardiac-thoracic surgery, central sterile processing, endoscopy, gerontological services, infusion therapy, nuclear medicine, orthopedic surgery, PICC line services, emergency psychiatry, reportable events, response to patient emergency, outpatient surgical services, ultrasound, and utilization review) and five of ten (5 of 10) contract services (biomedical engineering, blood bank, housekeeping, tele-radiology, and security). Findings: 1. Review of QAPI meeting minutes and reports dated 10/24/13, 1/23/14, 3/22/14, 6/24/14, and 9/26/14 indicated lack of evidence of quality evaluation of the following directly provided services/functions: cardiac-thoracic	S000406	The QUAPI program has been updated to include all areas of the hospital to include all contracted services beginning 1st Quarter 2015. Please see attached reporting schedule. The departments will report via the QUAPI committee to the Board of Directors. The Chief Operating Officer is responsible to ensure the reports are provided to the Committee and the Chief Nursing Officer is responsible for reporting the QUAPI minutes to the Board of Managers. This process will be monitored monthly by both the COO and the CNO.	02/27/2015

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	surgery, central sterile processing, endoscopy, gerontological services, infusion therapy, nuclear medicine, orthopedic surgery, PICC line services, emergency psychiatry, reportable events, response to patient emergency, outpatient surgical services, ultrasound, and utilization review. The records also lacked documentation of QAPI activity for the following contracted services: biomedical engineering, blood bank, housekeeping, tele-radiology, and security. 2. In interview on 11/18/14 at 3:30pm A2, chief nursing officer/QAPI manager, confirmed the above listed services and functions not to have been included in the QAPI program.			
S000420	410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1) Reportable events Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the hospital:			

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	(A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both. (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both. (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been			

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	carried out. (B) The following product or device events: (i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product. (ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism. (C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital. (D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug;			

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	(BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products. (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital. (v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability			

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	resulting from joint movement therapy performed in the hospital. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital. (iv) Patient death or serious disability associated with a fall while being cared for in the hospital. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the hospital. (iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital. Based on document review and interview, the hospital's quality assessment and performance	S000420	Reportable events are documented each month on a spreadsheet. Reportable events will be discussed at monthly QAPI	02/27/2015

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	improvement (QAPI) program failed to include reportable events in the program. Findings: 1. Review of QAPI meeting minutes and reports dated 10/24/13, 1/23/14, 3/22/14, 6/24/14, and 9/26/14 indicated lack of evidence of reportable events processes or evaluations. 2. In interview on 11/18/14 at 3:30pm A2, chief nursing officer/QAPI manager, confirmed the program did not include reportable events.		meetings beginning with 1st Quarter 2015. The 2014 Reportable event spreadsheet is attached.The Chief Operating Officer is responsible to ensure the reports are prepared monthly.The Chief Nursing Officer is responsible to ensure the reports are part of the QAPI minutes and reported to the Board of Managers	
S000512	410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(2)(A)(B)(i)(ii)(iii) (b) The food and dietetic service shall have the following: (2) A qualified dietitian, full-time, part-time, or on a consulting basis. If a consultant is used, he or she shall: (A) submit periodic written reports on the dietary services provided; and (B) provide the number of on-site dietitian hours commensurate with: (i) the type of dietary supervision			

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	required; (ii) the bed capacity; and (iii) the complexity of the patient care services. **Based on review of the dietitian job description responsibilities, patient record dietary reviews and staff interview, the hospital's consulting dietitian failed to document periodic written reports for five of five physician patient dietary orders.** **Findings included:** **1. On 11/18/14 at 2:00 p.m., review of the clinical dietitian's job description, updated 6/09/13, read:** **"Develops nutritional care plans and monitors patient response to care plan developed. Keeps thorough and updated information on patient profile sheets."** **2. On 11/18/14 at 11:15 a.m., review of five patient dietary orders** **(patient (Pt)#11 on 11/16/14 for a regular diet, Pt#12 on 11/14 for a heart healthy diet, Pt#13 on**	S000512	The Dietitian contract and license are attached. The twice weekly reports are attached for review.The Manager, Dietary Services is responsible for this evolution. She is to report to the Chief Operating Officer when a scheduled dietitian is not going to be available for her shift.The Chief Operating Officer and The Chief Nursing Officer will receive weekly reports provided by the dietitian as attached. These reports will be part of the Dietary QAPI plan and forwarded to the QAPI committee which in turn will report to the Board of Managers.	02/23/2015

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	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	10/24/14 for a diabetic diet, Pt#14 on 11/15/14 for a soft diet, and Pt#15 on 10/15/14 for a low sodium diet) failed to indicate each of these orders had been periodically reviewed by the hospital's consulting dietitian for care plan development or updated information on these patient's profile sheets. **2. On 11/18/14 at 12:30 p.m., employee #6, dietary manager, acknowledged the above-listed missing documentation.**			
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 policy review, observation and interview, the facility failed to provide a safe and healthful environment for the hospital that minimizes infection exposure to patients and visitors in 8 instances.	S000554	Kentuckiana Medical Center has purchased and is installing an Endoscope holder/cabinet for the Operating Room with a delivery date of 2-25-15. This cabinet will provide sufficient storage for the scopes and will not allow them to	02/25/2015

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	11/18/2014

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	Findings: 1. Hospital policy IC 1.02, Infection Control, dated 9/4/2012, state "Activities include the following: 7. Providing a safe environment consistent with nationally recognized infection control programs....11. Monitoring and evaluating practices of asepsis. 12. Limiting the spread of contagion through ...housekeeping, as well as other means." 2. The hospital policy IC 4.34, Endoscopes, dated 9/4/2012, does not address scope storage. 3. On tour of the surgery and central processing area, on 11/18/2014 at 0830 hours, in the presence of staff members #2, the Chief Nursing Officer (CNO) and #12, the Surgery Manager, it was observed that the facility's endoscopy scopes were stored in the sterile storage area. It was observed that one scope touched a soiled towel on the floor. The wall behind the scope storage hooks was soiled with fluid splashes. The steam room, which was through one door near the sterilization area, appeared to be unattended to, and had dirty boxes and other debris on the floor, and dusty equipment that was stored there. Towels on a cart where instruments come after their preliminary wash, and into the		touch the floor.The steam room will remain free of boxes and debris on the floor. Towels were removed from the cart and will not be placed on the cart in the future.Housekeeping has been in-serviced on proper procedures for cleaning patient rooms by watching hospital approved environmental services video and tested there after. All housekeeping staff have passed the test and will be required to do so prior to working at KMC. See attached test and subject matter of three videos.All nursing units will clean microwaves and refrigierators weekly at a minimum and as need in betweenThe Chief Nursing Officer and The Chief Operating Officer is responsible for the completion of all the task and will walk through the hospital daily to review if everything is being done correctly.	

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	150176	A. BUILDING 00 B. WING	11/18/2014

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	sterile central processing area, were soiled with a brownish substance. 4. On tour of the telemetry unit, on 11/18/2014 at 1100 hours, in the presence of staff members #2 and #11, the engineer/maintenance staff, it was observed that the pantry refrigerator had a sticky, dried substance on a shelf and under the bottom pull out drawer. Patient room 208, which had been cleaned by housekeeping and was ready for a new patient, had crumbs and a fork in the patient bedside table. There was also dirt and tape on the bed, and the bathroom floor was soiled. The patient bathroom contained a urinal of unknown origin. The crevices in the bed's siderails were soiled and contained crumbs. 5. On tour of the medical-surgical unit on 11/18/2014 at 1245 hours, in the presence of staff member #2, it was observed that the pantry microwave was soiled and the clean utility floor had much debris and dust. 6. On tour of the ICU unit, on 11/18/2014 at 1000 hours, in the presence of staff members #2 and #11, pantry refrigerator had sticky, dried substance on the door, on bottom shelf and under the bottom drawer. Patient room 8, which had been cleaned, had soil on the bedside			

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	table (including a straw under the top surface) and soil on the bed and wall behind the bed. There was tape on the siderail. 7. Staff members #2 and #11 agreed with the above findings, on 11/18/2014 at 1500 hours.			
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 document review and interview, the hospital medical staff (MS) failed to conduct biennial outcome oriented performance evaluations for 6 of	S000804	Kentuckiana Medical Center is implementing Ongoing Professional Practice Evaluation (OPPE). The documentation is attached for review. The Medical	02/27/2015

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	18 MS files reviewed (MD4, MD5, MD6, MD7, MD9, MD10). Findings: 1. Review of the document titled Medical Staff Rules and Regulations, adopted last by the MS and approved by the Board of Directors (GB) 9/4/12 indicated the following in corresponding sections: a. Part XXV. Medicine Department Rules and Regulations, #2: The Medicine Department shall have ongoing performance improvement and quality assessment review of physician's competence for those physicians holding either an active or associate staff designation. This shall be done on an ongoing basis. b. Part XXVI. Surgery Department Rules and Regulations, #2. The Surgery Department shall have ongoing performance improvement and quality assessment review of physician's competence for physician's holding either an active or associate staff designation. This shall be done on an ongoing basis. c. Section titled Anesthesiology Rules and Regulations #1. Standards for patient care in Anesthesiology, letter h. Availability of qualified personnel, iii. indicated: Competent personnel who continue to provide evidence of their		Staff Office will ensure compliance with the program. A performance evaluation form has been completed and will be utilized by the Chief of Medicine and the Chief of Surgery for evaluation at the end of Provisional Period. The form is attached for review. The Manager, Medical Staff office is responsible for the implementation of this evolution.The Chief Operating Officer is responsible for ensuring the forms are completed and forwarded to the Credentials Committee and the Medical Executive Committee Quarterly. The Medical Executive committee will forward their responses to the Board of Managers Quarterly.	

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	competence. 2. Review of the document titled Medical Staff Bylaws, adopted last by the MS and approved by the Board of Directors (GB) 9/4/12 indicated the following in corresponding sections: a. Section #10. Provisional Period, a. Scope and Duration: All new MS appointments...are provisional for a period of up to one (1) year ("Provisional Period")...During the Provisional Period, a provisional appointee's performance will be review and evaluated by the Department Chairperson, or his or her designee, for the Department with which the Practitioner is primarily affiliated... 3. Review of credential files for MD1 - MD12 and AH1 - AH7 indicated the following: a. MD4 file indicated reappointment date 9/30/14 with approved privileges for radiology. The file included a performance evaluation completed on 8/22/14 by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. b. MD5 file indicated reappointment date 6/28/14 with approved privileges for courtesy oncology. The file included a performance evaluation completed on			

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	150176	A. BUILDING 00 B. WING	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	8/7/13 by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. c. MD6 file indicated reappointment date 6/28/14 with approved privileges for hematology. The file included a performance evaluation, without indication of date complete, by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. d. MD7 file indicated reappointment date 3/25/14 with approved privileges for internal medicine. The file included a performance evaluation completed on 3/17/14 by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. e. MD9 file indicated reappointment date 3/26/13 with approved privileges for pulmonary. The file included a performance evaluation completed on 9/3/13 by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. f. MD10 file indicated reappointment date 3/26/13 with approved privileges for			

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	150176	A. BUILDING 00 B. WING	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	thoracic surgery. The file included a performance evaluation completed on 1/27/14 by an outside hospital based on that facility's data. The file lacked documentation of a biennial outcome oriented performance evaluation completed by the facility's MS. 4. In interview on 11/18/14 at 2:20pm A9, director of credentialing, indicated physician evaluations are done by an outside facility by medical persons and confirmed the evaluation is based on that facility's data.			

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S001024	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation and interview, the facility failed to monitor expiration dates of medicines in one instance. Findings: 1. On tour of the Telemetry unit on 11/18/2014 at 1530 hours with staff member #2, Chief Nursing Officer, 9 bottles of 30 milliliters of Normal Saline for injection, which had expired on 2/1/2014, were found in a storage bin, in a cabinet near the Pyxis machine (medication dispensing system).	S001024	Materials Management has rounded and all expired stock has been removed. Each department is responsible establish a procedure to rotate stock in a timely manner and eliminate expired stock from staying on the shelf.Materials Management will round bi-weekly to ensure stock is being rotated appropriately.The Chief Operating Officer will round Monthly to ensure compliance.	02/23/2015

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	150176	A. BUILDING 00 B. WING	11/18/2014

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	2. Staff member #2 agreed, on 11/18/2014 at 1530 hours, that the Normal Saline bottles had expired.			
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 observation and interview, the hospital created/maintained unsafe conditions for one of twelve kitchen work areas.** **Findings include:** **1. On 11/17/14 at 11:45 a.m., two unchained soda cylinders were observed positioned in the aisle of one kitchen work area (dry**	S001118	The Soda Cylinders have been adequately chained. To prevent this from happening again, the checking of the chain has been added to the daily check list for the Dietary Manager.Dietary Manager is responsible for compliance.Dietitian will inspect this also on her weekly rounds.	02/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	storage room). **2. On 11/17/14 at 11:45 a.m., staff member #1, chief operating officer, acknowledged the presence of these unchained cylinders.**			
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 document review, observation and interview, the hospital failed to provide evidence of preventive maintenance (PM) on all equipment in 11 instances (centrifuge, dishwasher, EKG machine, floor scrubber/buffer, overhead adjustable lights, perfusion pump, renal dialysis machine, ultrasound machine, ventilator, anesthesia machines, and blood warmers).	S001164	The floor buffer being provided by the contract housekeeping service has been removed. Kentuckiana Medical Center has contracted with third parties to provide Preventive Maintenance (PM) on much of the equipment and have received quotes to complete the rest of the requirement. See attached Documents. Plant Operations is responsible for complete compliance of this initiative.	02/27/2015

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	150176	A. BUILDING 00 B. WING	11/18/2014

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	Findings: 1. On 11/17/14 at 2:00pm, in the presence of A2 and A10, the CNO and plant operations manager, during tour of an out-lot storage building an Elky Pro, floor buffer type machine was observed to be in rusty condition. Evidence of PM was requested of A10 at that time. 2. Review of PM documents lacked evidence of PM on the following equipment: centrifuge, dishwasher, EKG machine, floor scrubber/buffer, overhead adjustable lights, perfusion pump, renal dialysis machine, ultrasound machine, ventilator, anesthesia machines, and blood warmers. 3. In interview on 11/18/14 at 12:30pm, A10 confirmed lack of documentation for PM on the above equipment and no further documentation was provided prior to exit.			
S001168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a			

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	150176	A. BUILDING 00 B. WING	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	discharge log with initialed entries shall be maintained. Based on document review and interview, the hospital failed to ensure defibrillators were discharged in accordance with manufacturer's recommendation in one (1) instance. Findings: 1. During tour of the hospital on 11/17/14 at 1:40pm in the presence of A2 and A12, the chief nursing officer and ECHO staff personnel, it was observed in the ECHO (echocardiogram) area, a Zoll M Series defibrillator and facility log titled 2014 CT Scan Crash Cart Defibrillator Checklist. The log indicated once daily checks of the defibrillator. The manufacturer's manual was requested at that time to determine recommendations. 2. Review of documentation provided as the Zoll M Series manual included one page titled Chapter 1 Maintenance Tests and indicated the M Series has two check out procedures: the operator's shift checklist and the extensive six-month maintenance tests checkout procedures. A list of maintenance tests to be performed as preventive maintenance by a qualified biomedical technician was included on this page, but the document	S001168	A Zoll M Series Operator's Guide has been obtained for each defibrillator in the facility and is attached to them. Each Defibrillator is checked daily with the exception of the areas not in use on the weekends. These areas are secured and the Equipment is NOT utilized. Please see attached the cover page for the Zoll as well as the check list for the different defibrillators in the facility.Each Department Head is responsible for ensuring the checks are completely daily.The House Supervisor will provide oversight on their rounds throughout the hospital on a daily basis.	02/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	lacked evidence of the operator's shift checklist. No further documentation was provided prior to exit. 3. In interview on 11/17/14 at 1:40pm, A12 indicated a manual was not available, but he/she could find one online and agreed to provide. A12 further indicated that the unit in which the defibrillator was stored was unlocked during hospital hours and that the defibrillator was available for use at all times during all shifts. He/she verified the machine to be checked only once daily when the unit was open.			
S001172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and			

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	(C) Safe practice. Based on observation, the hospital failed to maintain the facility and its contents in a clean and orderly manner in two (2) instances (ultrasound room, CT scanner testing room). Findings: 1. During tour of the facility on 11/17/14 between 1:30pm and 2:30pm in the presence of A1 and A10, the CNO and Plant Operations Manager, the following was observed: a. In the ultrasound room, indicated to be utilized as a leased out cardiac testing room, was an Ergoselect electric bike with hair-like debris and heavy dust and dust globs on the floor. b. In a CT scanner testing room, heavy dust was noted on the baseboards.	S001172	The leased Ergoselect Electric Bike has been removed and the space has been vacated by the contractor. A terminal cleaning has taken place in the CT room and will be terminally cleaned daily after hours.The Housekeeping Supervisor will provide a report to the Chief Operating Officer daily as to the number of housekeeping staff per shift and their assigned areas. See Attached.Plant Operations will round daily and review the cleanliness of the facility.The Infection Nurse will provide the Chief Operating Officer and the Chief Nursing Officer weekly reports or more often as needed of any area she feels must be addressed.The Chief Operating Officer has ultimate responsibility to ensure the facility is maintained in a clean and orderly manner.	02/23/2015
S001404	410 IAC 15-1.6-1 ANESTHESIA SERVICES 410 IAC 15-1.6-1(a) (a) If the hospital furnishes anesthesia services, the service shall meet the needs of the patients served, within the scope of the services offered, in accordance with acceptable standards of practice, and be under the direction of a qualified physician. The service is responsible for all anesthesia administered in the hospital.			

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	11/18/2014

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	Based on document review and interview, the hospital failed to provide evidence of anesthesia services being under the direction of a qualified physician. Findings: 1. In interview on 11/18/14 at 12:20pm A1, CNO, indicated the following: a. The facility currently did not have a director of anesthesia. b. The previous director of anesthesia was no longer on active medical staff. c. Anesthesia services were presently being coordinated by CRNA, AH7 d. MD11 is available for consult with AH7 and MD11 will be director of anesthesia when on staff full-time, but is not currently in-house. During this interview, the following was requested of A2: a. Documentation of resignation or departure date of MD13, previous anesthesia director. b. Governing board (GB) meeting minutes or other evidence of approval of current anesthesia director 2. In interview on 11/18/14 at 12:50pm A1, COO, indicated MD13 left the country in early 2014, was on medical leave, and has not returned to duty at the hospital. The following was requested of	S001404	Dr. James Photiadis, Board Certified in Anesthesiology, has assumed duties as Director of Anesthesia. This was accomplished by a phone vote of the Board of Managers and will confirmed in writing at the next Board of Managers meeting.	02/23/2015

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	A1: a. Documentation of resignation or departure date of MD13, previous anesthesia director. b. Governing board (GB) meeting minutes or other evidence of approval of current anesthesia director. 3. Review of GB meeting minutes dated 12/31/13, 3/25/14, 9/3/14, & 6/24/14 lacked documentation of resignation of MD13 and/or approval of a qualified physician to provide anesthesia director services in the absence of MD13. 4. Review of the credential file for MD13 lacked documentation of GB or medical staff (MS) approval to direct anesthesia services.			