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	10/29/2014

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S000000	This visit was for a State hospital licensure survey. Dates: 9/27/2014 through 9/29/2014 Facility Number: 006218 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: cxlaughlin 11/12/14	S000000		
S000320	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G) (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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	(G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee. Based on document review and staff interview, the hospital failed to ensure a post offer physical examination was conducted on 3 of 21 staff as per hospital policy (CNA#1, RN#8, and PRN #10). Findings included: 1. The 2014 Employee Health Program H-IC 05-001 indicated a Pre-placement history or physical (this may be by a personal physician, facility Medical Director or facility's preferred provider). Attached to the policy is a Post Hire Physical Kindred Indianapolis South form to be filled out by a health care practitioner on the history of the employee's pre-employment physical. 2. 21 staff member's health care files were reviewed. It was noted that three employees (CNA#1, RN#8,	S000320	1. Deficiency Correction: Electronic HR process does not effectively allow Employee Health Nurse to document a post hire physical. All 3 employees with missed physicals were contacted and appropriate documentation completed to meet compliance. The employee Health Nurse will utilize the paper version of the post hire physical with all future hires. The completed documentation will be filed in the employee health file. 2. Deficiency Prevention: All new hire health screens will be audited by the Employee Health Nurse and presented thru Quality Council. 3. Responsible Party: Employee Health Nurse 4. Correction Date: 10/31/2014	10/31/2014

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	and PRN #10) did not have a post offer physical exam within their health care employment file. 3. At 12:00 PM on 10/28/2014, staff member #1 (CEO) indicated that their hospital is the test hospital for Human Resources. This test program is an online application that asks if the employee is healthy to perform their assigned job responsibilities and the post offer physical will not be required anymore.			
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 and interview, the facility failed to ensure a safe environment for patients by ensuring clean supplies and equipment were protected from contamination. Findings included:	S000554	1. Deficiency Correction: Leadership and line staff conducted an entire EOC sweep of facility on 10/31/2014. All outside shipping boxes removed from any clean areas. All cardboard boxes removed from floor.	10/31/2014

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	1. During the tour of the second floor Medical/Surgical Unit at 8:45 AM on 10/28/14, accompanied by staff member #2, the Director of Quality Management, and #3, the Chief Corporate Officer, numerous outside shipping boxes of supplies were observed in the linen room, some on the floor, and some on the cart with the clean linen. Another shipping box of supplies was observed on the shelf with clean, open supplies in the clean utility room. 2. During the tour of the Dialysis Room at 9:40 AM on 10/28/14, accompanied by staff members #2 and #3, an outside shipping box of supplies was observed on the top shelf of a rack containing clean supplies. 3. During the tour of the Pharmacy at 10:15 AM on 10/28/14, accompanied by staff members #2 and #3, numerous outside shipping boxes of supplies were observed in the storage room, some on the floor, and some on the shelves with clean supplies. 4. During the tour of Materials Management at 1:15 PM on 10/28/14, accompanied by staff member #10, the Operation Manager, outside shipping boxes of supplies were observed on the top shelf of a rack containing open, clean		2. Defiencicy Prevention: Any products that are received in outside shipping boxes will now be removed and either stored in their original containers or removed and stored individually in an appropriate plastic bin. Education provided to staff members during daily patient safety huddles and morning flash. Weekly EOC rounds conducted by leadership will ensure compliance. Results of rounding findings will be provided in real time at the following am flash meeting and thru Quality Council. 3. Responsible Party: Materials Manager, Food Service Manager, Housekeeping Manager and Pharmacy Director. 4. Correction Date: 10/31/2014	

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	supplies. 5. At 2:00 PM 10/28/14, staff members #2 and #3 confirmed the risk of clean supplies being contaminated by the storage practices.			
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, manufacturer's literature, policy and procedure review, and interview, the facility failed to follow the manufacturer's instructions for disinfecting equipment used for procedures. Findings included:	S000596	1. Deficiency Correction: The Steris will now be utilized for all scope cleaning. Cidex will only be used as a back-up when the Steris is unavailable or on an as needed basis for additional equipment. Cidex will be mixed at time of cleaning and disposed of at the conclusion of the cleaning process. Step by step	12/03/2014

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	1. During the tour of the Decontamination Room at 11:00 AM on 10/28/14, accompanied by staff member #2, the Director of Quality Management, and #3, the Chief Corporate Officer, a container of Cidex OPA high level disinfectant was observed on the counter, along with test strips and a log book on the shelf. A scrubbing brush was observed hanging on the faucet of the sink. Gloves were the only PPE (Personal Protective Equipment) observed in the area. Posters on the wall depicted procedures for cleaning and using enzymatic cleaners, but no procedures specific to Cidex OPA. 2. The manufacturer's instructions for the use of Cidex OPA were reviewed. The document indicated, "Precautions: Follow OSHA Bloodborne Pathogens Universal Precautions when handling and cleaning soiled devices. 1. When disinfecting devices, use gloves of appropriate type and length, eye protection and fluid-resistant gowns." The instructions continued under Rinsing Instructions, "a) Following removal from Cidex OPA Solution, thoroughly rinse the semi-critical medical device by immersing it completely in a large volume (e.g. 2 gallons) of water....Keep the device totally immersed for a		cleaning instructions following manufactures guidelines for Cidex placed in a binder in the cleaning room. The multi-use brush was disposed of and only single use disposable brushes to be utilized during cleaning process. PPE storage device to be placed on cleaning room door to ensure availability of all required PPE. Clearly defined fill lines to be placed on all appropriate solution tubs and graduated fill cups will be utilized when diluting any solution to ensure accurate ratio. Education provided to all staff members that will utilize Cidex for cleaning equipment. 2. Deficiency Prevention: Cidex to be utilized on an as needed basis only. QC will be completed at the time Cidex is utilized. Cidex will be disposed of at the conclusion of the cleaning process. RT Director to review log book weekly to ensure compliance is met. 1:1 education and PI to be provided to any staff in non-compliance. Findings to be presented to Quality Council. 3. Responsible Party: Nurse Manager, CCO, Respiratory Manager, Infection Control Nurse 4. Correction Date: 12/3/2014	

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	minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. ... Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing or any other purpose. Repeat the procedure 2 additional times for a total of 3 rinses, with large volumes of fresh water to remove Cidex OPA Solution residues. ...2. Sterile Water Rinse: The following devices should be rinsed with sterile water, using sterile technique when rinsing and handling: ...When practical, bronchoscopes, due to a risk of contamination from potable water supply." 3. The facility's policy "Endoscope Reprocessing", original date of 02/2013, indicated, "To provide guidelines for staff performing cleaning and high level disinfecting of bronchoscopes, gastroscopes, fiberoptic laryngoscopes and accessories. ...High-level disinfectant and chemical cleaner manufacturers' written instructions will be followed regarding: ...water quality ...rinsing." The policy did not specify any step-by-step instructions regarding using sterile water or rinsing three separate times. 4. At 11:30 AM on 10/28/14, the			

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	Decontamination Room was again visited with staff member #15, a respiratory staff member who performed the high-level disinfecton using the Cidex. He/she described the cleaning procedure using the scrub brush, then indicated either the ventilator parts or the bronchoscopes soaked in the Cidex OPA for at least 12 minutes. He/she indicated he/she rinsed the equipment in a basin in the sink one time, then proceeded with the rest of the procedure. He/she indicated he/she usually brought his/her own PPE with him/her. He/she indicated he/she cleaned the scrub brush off and sometimes soaked it in the Cidex OPA.			
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			

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	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 medical record review, policy review, and interview, the facility failed to follow their policy for 1 of 5 patients (#N1) who received blood transfusions and failed to ensure their policy provided the specific guidelines for administering blood transfusions at their facility. Findings included: 1. The medical record for patient #N1 indicated a physician order from 07/06/14 to type and crossmatch 2 units of packed red blood cells and transfuse each unit over 2 hours with Lasix 20 mg. (milligrams) given intravenously between the units. The order was transcribed by the nurse at 0822 on 07/06/14. The record indicated the patient's hemoglobin was 7.0 (normal range 12- 14), the blood was collected at 1006 on 07/06/14, and there were no difficulties with crossmatching. The first unit of blood was started at 1510 and completed at 1705, but the record lacked documentation of the one hour post transfusion vital signs. Documentation	S000952	1. Deficiency Correction: Addendum will be added to core policy to provide step by step instructions for requesting and receiving blood products from outside lab services. Addendum will also include documentation requirements for any case where multiple units are ordered and there is a time span greater than 4 hours between transfusions. Education will provided to nursing staff describing above process during patient safety huddles and staff meetings. 2. Deficiency Prevention: Nursing Manager to audit all blood product transfusions. Education and PI to be provided 1:1 to any staff member that does not meet compliance related to blood product administration. Audit findings to be provided to Quality Council for review. 3. Responsible Party: Nurse Manager, CCO, DQM 4. Correction Date: 12/10/2014	12/10/2014

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	indicated the Lasix was given at 1710 on 07/06/14. The second unit of blood was not started until 0104 on 07/07/14, eight hours later, with no documented explanation for the delay. 2. The facility policy "Transfusion Therapy", last revised 08/2013, indicated, "2. Vital signs (VS) will be observed and documented at minimum at the following intervals/times: ...Check VS at 1 hour post transfusion. ...3. Call blood bank for availability of blood components. Procure blood components from blood bank. ...2. Visually inspect each blood component container for clots, hemolysis, leaks, or discoloration." The policy did not address calling the contracted facility, receiving the blood from a courier service, checking the temperature of the blood when removing from the transport container, or a time frame for calling, obtaining, and transfusing more than one unit of blood. 3. At 2:05 PM on 10/28/14, staff member #2, the Director of Quality Management, and staff member #16, the lab manager, discussed the transfusion policy and the medical record for patient #N1. #16 confirmed there were no documented issues with crossmatching the blood and 8 hours was an extended time between the transfusions, but maybe			

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	the unit was really busy. #2 concurred with the possibility of an emergency or problem on the unit, especially since the last set of vital signs for the first unit was not documented, but confirmed there was no documentation to explain the delay. Both staff members indicated there was paperwork that arrived with the blood from the courier service where the temperature check was documented, but confirmed the current policy did not accurately describe the procedure to follow to transfuse blood products at this facility.			
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 discharge log with initialed entries shall be maintained. Based on observation, document review, interview, policy and procedure review, and manufacturer's instructions, the facility failed to follow their policy and the manufacturer's recommendations for daily checks of the defibrillators to ensure emergency readiness.	S001168	1. Deficiency Correction: A new checklist that follows manufactures recommendations for monitoring HeartStart XL defibrillator was created and replaced the current check list. The checklist specifically addresses ac power and verifying the unit is plugged in and charging. Education has been provided on the	11/03/2014

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	Findings included: 1. During the tour of the Special Care Unit at 10:30 AM on 10/28/14, accompanied by staff members #2, the Director of Quality Management, and #3, the Chief Corporate Officer, the defibrillator on the emergency crash cart was observed unplugged. The "Emergency Equipment Surveillance" log indicated the morning check had been done; however, the nursing signature only indicated the crash cart lock, monitoring pads, electrodes, and microshield were checked. 2. Review of the facility's "Emergency Equipment Surveillance" logs for the defibrillators on the crash carts only had areas for documentation of checks for the crash cart lock, monitoring pads, electrodes, and microshield for nursing and the oxygen tank, ambubag, and RT box lock for respiratory staff. 3. At 10:50 AM on 10/28/14, staff member #13, the day nursing supervisor, indicated she noticed the defibrillator was unplugged, but was waiting for the nurse she was orienting, who had performed the morning check, to arrive on the unit so that she could review this process with her. However, she confirmed there was no area to document on the logs to		new changes in the checklist during the charge nurse staff meeting. 2. Deficiency Prevention: Nurse Manager receives the crash cart log at the conclusion of each month for review. Non-compliance is addressed with 1:1 education and PI if appropriate. The results of log review are presented to Quality Council. 3. Responsible Party: Nurse Manager, CCO 4. Correction Date: 11/3/2014	

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	indicate this check was performed. 4. At 10:55 AM on 10/28/14, staff member #11, the nurse orienting, reviewed the checks she had performed and indicated she did not check that the defibrillator was plugged into the wall, but only checked the plug into the unit. 5. The facility policy "Hospital Wide Plan for Resuscitative Services", last reviewed 04/25/14, 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: ...b. Check the defibrillator (according to manufacturer instructions)." 6. Review of the "HeartStart XL + Shift Checklist" from the manufacturer, Philips, indicated, "Inspect the HeartStart XL +, accessories, and supplies at the change of every shift, per AHA guidelines." The form listed 13 items to be checked, including, "AC power cord-plugged in, green light on."			
S001186	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)			

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	(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on documentation review and staff interview, the facility failed to provide documented fire drills for the first shift of the second quarter of 2014. Findings included: 1. Fire Safety Management Plan policy EC.02.03.01 (last approved 2/2014) indicated 1 fire drill per shift per quarter. 2. The hospital fire drill documentation were reviewed for	S001186	1. Deficiency Correction: A monthly fire drill schedule was created by the Plant Operation Manager. Schedule clearly indicates what shift the drill is due for each month. Plant Operations Manager must be notified if a scheduled drill cannot be conducted for any reason. The drill is rescheduled at that time to ensure compliance is met. 2. Deficiency Prevention: Plant Operations Manager audits all fire drills prior to month end to verify and ensure any required drill has been conducted.	11/21/2014

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

(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
	the last 2 quarters of 2013 and the first 2 quarters of 2014. The documentation provided revealed the hospital operated primarily on two shifts. The evidence provided failed to document a fire drill for the first shift of the second quarter in 2014. 3. At 2:45 PM on 10/28/2014, staff member #10 (Operation's Manager) indicated he/she confirmed the hospital had no documented fire drill for the first shift of the second quarter in 2014.		3. Responsible Party: Plant Operations Manager 4. Correction Date: 11/21/2014	