

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152007	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 W 10TH ST INDIANAPOLIS, IN 46222
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S 000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 006106</p> <p>Survey Date: 1-12/14-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 03/02/15</p>	S 000	No response required	
S 554 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the hospital</p>	S 554	S 0554 # 1 Action Taken A tube	01/16/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>created 3 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 1-13-15 at 3:30 pm in the presence of employee #A2, Quality Management Director, it was observed in the Renal Dialysis Room, there was a drain tube from the dialysis machine in which the end tip of the tube was below the top plane of the drain hole, approximately 2 inches into the hole. This configuration, the tip below the top plane of the hole, caused the potential for bacterial growth since there was reduced air circulation. On 1-13-15 at 3:30 pm in the presence of employee #A2, it was observed in the Renal Dialysis Room, there was a hole in the wall approximately 3 inches in diameter which was uncovered. This condition allowed for dirt, dust and other substances to more easily enter a patient care area for patients undergoing renal dialysis treatment During observations beginning at 9:30 AM on 1/13/15, the following expired processed instruments were observed: <ol style="list-style-type: none"> One (1) knife with an expiration date 		<p>stabilizer was installed to prevent tubes from becoming displaced Prevention Dialysis staff will check tube placement on dialysis run days to ensure correct tube placement Monitoring 1) Infection Preventionist will perform random checks to verify correct tube placement 2) Correct tube placement has been added to our monthly environmental rounds checklist 3) Rounding results and actions taken will be reported through Infection Prevention & Control Committee meetings and up through Quality Council, MEC and Governing Board. Responsibility Infection Preventionist S 0554 # 2 Action Taken Plant Operations repaired the open hole in the dialysis unit wall. Prevention The Dialysis staff now has access to the work order system for notifying Plant operations of needed repairs Monitoring 1) Plant Operations and Infection Preventionist will round on Dialysis unit monthly to ensure no open holes in walls. 2) Rounding results and actions taken will be reported through Infection Prevention & Control committee meetings and up through Quality Council, MEC and Governing Board Responsibility Infection Preventionist S 0554 # 3 Action Taken The expired items were immediately removed to prevent usage. A check was performed throughout the facility to ensure no additional expired</p>	

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S 592 Bldg. 00	<p>of 11/21/08 was observed in the wound/ostomy supply room.</p> <p>B. One (1) tissue forceps with an expiration date of 11/21/08 was observed in the wound/ostomy supply room.</p> <p>C. One (1) knife handle with an expiration date of 11/21/08 was observed in the wound/ostomy supply room.</p> <p>D. Two (2) forceps was missing the expiration dates was observed in the wound/ostomy supply room.</p> <p>4. Interview with staff member #N3 (Chief Clinical Officer) at 9:30 AM on 1/13/15 verified that these items were expired.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(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:</p> <p>(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:</p> <p>(i) Sanitation.</p>				<p>items in any areas Prevention / Monitoring Instruments will be monitored for integrity and expiration dates on a monthly basis by wound care coordinator. A check for expired supplies will also be performed during monthly rounding on assigned areas. Issues will be corrected immediately and findings will be reported through the IP&C committee meetings and up through Quality Council, MEC and Governing Board. Responsibility Wound Care Coordinator</p>		

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	<p>Based on policy and procedure review, observation and interview, the facility failed to ensure that the environment was clean and sanitary in 4 instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Storage of Medications" with release date of 8/20/14 states on page 1: "Medications must be stored under proper conditions of sanitation,". 2. Facility policy titled "Terminal Cleaning of Patient Rooms" with effective date of 06/2011 states on page 1, item 5, letter c "Dust the TV and rotate the duster over the wires and screen". 3. During observations beginning at 9:30 AM on 1/13 15, the following observations were made in the minor procedure suite: <ol style="list-style-type: none"> A. Minor procedure room had dust on top of procedure lights. B. The hopper in the soiled/decontamination room was grossly soiled. 4. During observations beginning at 10:30 AM on 1/13/15, the following observations were made in the Special Care Unit: <ol style="list-style-type: none"> A. The crash cart had dust covering the 	S 592	<p>S 0592Action Taken1) The housekeeping supervisor was educated on the correct cleaning process while rounding with leadership members. Housekeeping Supervisor held a mandatory training inservice with all EVS staff members and demonstrated the correct cleaning process to be followed 2) A cleaning schedule along with defined responsible parties was developed so all responsible parties know which cleaning responsibilities they have and all have been educated 3) The Respiratory staff will be responsible for ensuring all crash carts are dust free during crash cart daily checks 4) Pharmacy staff will be responsible for ensuring all medication refrigerators and all medication storage bins are cleaned on a monthly basis and as needed 5) Housekeeping staff is responsible for dusting (high and low) and daily cleaning of hoppers 6) Housekeeping is responsible for Daily cleaning of all pantry area Microwaves daily 7) Dietary (Morrison's) is responsible for cleaning of all pantry area refrigerators as well as all kitchen / cafeteria equipment daily 8) Materials Management is responsible for ensuring all supply storage bins are clean on an as needed basis 9) Lab Manager is responsible for cleaning specimen and all laboratory related refrigerators</p>	01/26/2015

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	<p>surface.</p> <p>B. The hopper in the soiled utility room was grossly soiled.</p> <p>C. The inside of the medication refrigerator in the medication room had spills and dirt on the shelves.</p> <p>D. The inside of the microwave in the patient pantry had dried food on all surfaces.</p> <p>5. During observations beginning at 11:10 AM on 1/13/15, the following observations were made in Medical/Surgical East Unit:</p> <p>A. The crash cart had dust covering the surface.</p> <p>B. The inside of the pantry refrigerator had spills and dirt on the shelves.</p> <p>C. The inside of the medication refrigerator in the medication room had spills and dirt on the shelves.</p> <p>D. The inside of the microwave in the patient pantry had dried food on all surfaces.</p> <p>E. The medication bins in the medication room were dusty.</p> <p>6. During observations beginning at 11:45 AM on 1/13/15, the following observations were made in Medical/Surgical West Unit:</p> <p>A. The crash cart had dust covering the surface.</p> <p>B. In unoccupied patient room 207, the</p>		<p>and storage areas <u>Prevention / Monitoring</u> Following housekeeping staff completing patient room cleaning, the housekeeping supervisor will check rooms to ensure all areas are appropriately cleaned. The Infection Preventionist will perform a final check to ensure all areas / items are clean and dust free. All areas will also be checked during monthly rounding for cleanliness. Results will be presented through the Infection Prevention & Control Meetings, Quality Council, MEC and Governing Board. <u>Responsibility</u> Infection Preventionist</p>	

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S 952 Bldg. 00	wires and the screen of the TV were dusty. 7. Staff member #N3 indicated during observations beginning at 11:45 AM on 1/13/15 that there is no cleaning schedule for the medication refrigerator, pantry refrigerator or pantry microwave. 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, patient record review, and staff interview the facility failed to administer 4 of 6 transfusions according to approved medical staff policies and procedures.	S 952	S 0952 Action Taken The nursing staff is currently in the process of being re-educated on our blood administration policy and vital sign requirements by our Clinical Educator <u>Prevention / Monitoring</u> The nursing supervisor	03/20/2015

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S 022 Bldg. 00	<p>Findings include:</p> <p>1. According to Policy Number H-PC 08-072, Effective Date: 11/09, Revised Date: 08/2013 titled Transfusion Therapy: "2. Vital Signs (VS) will be observed at a minimum at the following intervals/times: Pre-transfusion baseline VS immediately prior to initiation of transfusion"</p> <p>2. Review of 6 patient transfusion records indicated the following: T#1 previtals at 1720, the same time the transfusion started, T#3 previtals at 0005, the same time the transfusion started, T#5 previtals at 0900, the same time the transfusion started, and T#6 previtals at 1355, the same time the transfusion started.</p> <p>3. On 1/13/15 staff person (SP) #4 acknowledged the medical staff starting T#1, T#3, T#5, and T#6 did not follow approved medical staff policy/procedures by doing previtals before the transfusions were started.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of</p>		will be monitoring blood vital signs and re-educating staff on the policy for any outliers when identified. The lab manager will be monitoring all blood administration vital signs and will notify the Chief Clinical Officer of any outliers. Results will be reported at Clinical Services / Patient Safety committee meeting and up through Quality Council, MEC and Governing Board <u>Responsibility</u> Chief Clinical Officer				

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S 186 Bldg. 00	<p>all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation, the facility failed to appropriately store medications in 1 instance.</p> <p>Findings:</p> <p>1. On 1-12-15 at 11:40 am in the presence of employee #A5, Pharmacy Director, it was observed in the Pharmacy there was a box of medication on a shelf. The top flap of the box was open. The package indicated Protect from Light. Thus, the contents were exposed to light. It was observed the box contained 22 1 ml vials of Phenylephrine, 10mg/ml. It was also observed each vial indicated Protect from Light.</p> <p>2. Due to the prolonged exposure to light, the above items may have become ineffective.</p> <p>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)</p>	S 022	<p>S 1022Action TakenThe medication was immediately removed and discarded through the appropriate process <u>Prevention</u>1) When light sensitive medications are opened they will be immediately placed in Amber bags to protect from light.2) Director of Pharmacy educated all Pharmacy staff on the need to ensure light sensitive medications are protected from light.MonitoringPharmacy staff will check to ensure all light sensitive medications are properly protected from light during monthly Pharmacy inspections. Any outliers will be immediately corrected and findings will be reported through PNT Committee meetings and up through Quality Council, MEC and Governing BoardResponsibilityPharmacy Director</p>	01/14/2015	

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	<p>(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:</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy in 1 of 8 instances.</p> <p>Findings:</p> <p>1. Review of facility Policy Number: SAF, 9, entitled FIRE PLAN, approved 6-27-14, indicated fire drills will be conducted once per quarter for each shift. In interview on 1-12-15 at 10:30 am, employee #A4, Operations Manager, indicated there were 2 nursing shifts, thus 2 drills per quarter.</p>	S 186	<p>S 1186 <u>Action Taken</u> The fire drill schedules have been placed on plant operations calendars to ensure compliance is maintained with one drill per shift per quarter <u>Prevention / Monitoring</u> The Plant Operations Manager has created calendar reminders for fire drills and created a schedule to ensure compliance is maintained. Compliance with fire drills will be reported through Environment of Care committee</p>	01/15/2015

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S 197 Bldg. 00	<p>2. Review of fire drills conducted at the facility for calendar year 2014, indicated there was no fire drill conducted for the second shift in the first quarter (January, February, March).</p> <p>3. In interview, on 1-13-15 at 11:00 am, employee #A4 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(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:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to have written documentation of a regular state or local fire inspection, or request of same, for calendar year 2014.</p> <p>Findings:</p> <p>1. On 1-12-15 at 10:30 am, employee #A4, Operations Manager, was requested to provide documentation of the</p>	S 197	<p>meetings and up through Quality Council, MEC and Governing Board <u>Responsibility</u> Plant Operations Manager</p> <p>S 1197 <u>Action Taken</u> The Fire Marshall was called and our Annual Fire Inspection was completed on January 14, 2015 right after survey closing <u>Prevention / Monitoring</u> Plant Operations Manager and Director of Quality Management have placed calendar</p>	01/14/2015

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	<p>hospital's most recent State or local fire inspection, or request for inspection, for calendar year 2014.</p> <p>2. In interview, on 1-13-15 at 9:30 am, employee #A4 indicated the last time there was a documented fire inspection was on 5-16-13 and there was no documentation of request for an inspection in calendar 2014. No further documentation was provided prior to exit.</p>				<p>reminders on their calendars to ensure the Fire Marshall is called in December of each year requesting our annual fire inspection to be completed</p> <p>Compliance with fire inspections will be reported through Environment of Care committee meetings and up through Quality Council, MEC and Governing Board <u>Responsibility</u> Plant Operations Manager</p>		