

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150010	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2016
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NAME OF PROVIDER OR SUPPLIER ST VINCENT KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 1907 W SYCAMORE ST KOKOMO, IN 46904
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S 0000 Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 4/4/2016 to 4/6/2016</p> <p>Facility Number: 005010</p> <p>QA: cjl 05/24/16</p> <p>IDR Committe held on 07-27-16, Tag S0556 deleted. JL</p>	S 0000		
S 0362 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p>			

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>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and interview, the facility failed to notify Indiana Organ Procurement Organization (IOPO) for 5 of 182 hospital deaths in 2015.</p> <p>Findings included:</p> <p>1. Review of Hospital Procurement Agreement indicated "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital." The Hospital Procurement Agreement with IOPO was last signed 6/22/15.</p>	S 0362	<p>All deaths after June 9, 2016, will include the completion of the death note in the Electronic Health Record (EHR), prior to this time the documentation was completed on a paper form. All nursing staff has been educated on the requirement to use the 'Death Note' in the EHR. The death note requires documentation of Indiana Donor Network (IDN) notification and verification number and will not allow completion without IDN verification. A death checklist is also included in the death packet and the IDN reminder is highlighted for easy visual reference</p> <p>To assure compliance is maintained with the new process; all deaths with</p>	06/09/2016			

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S 0406 Bldg. 00	<p>2. Review of St. Vincent Hospital Kokomo Donation 2015 Statistics and Benchmarks report identified the hospital had 182 deaths in 2015 and 177 of those deaths were reported to IOPO. Therefore, the report documented the 5 deaths that were not reported to IOPO: 1/1/15 - ICU; 2/19/15 - ER; 7/6/15 - Nursery; 10/21/15 - ICU; and 11/12/15 - ICU.</p> <p>3. At 3:50 PM on 4/4/2016, staff member #3 (Register Nurse) confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and 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:</p>		<p>be audited quarterly and compared to the IDN supplied report. Director of Emergency Services is responsible.</p>				

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	<p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to ensure two of two services (Electroencephalography [EEG] and Biohazard Waste Hauler) were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the 2016 St. Vincent Kokomo Patient Safety Program indicated "This is a Patient Safety and Quality Committee of the Board of Directors with the purpose of assisting the Board in the oversight and guidance of hospital wide efforts of evaluating, monitoring, and improving the quality of care provided at the hospital." The Patient Safety Program was last revised January 2016. Review of the Patient Safety & Performance Improvement Quality Council dashboards and minutes for 2015 indicated the documents that were provided lacked evaluation or addressing the following services: Electroencephalography (EEG) and Biohazard Waste Hauler. 	S 0406	<p>By June 8, 2016, both Electroencephalography (EEG) and Biohazard Waste Hauler Services Performance Improvement measures have been added to the Hospital-wide Quality & Performance Improvement Scorecard for FY 2017. These services will be displayed on the dashboard beginning with July 2016 data and reported to the Patient Safety and Quality Committee, Quality Committee of the Board and the Board of Directors quarterly. Director of Quality is responsible.</p>	06/08/2016

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S 0606 Bldg. 00	<p>3. In interview at 2:30 PM on 4/4/2016, staff member #2 (Register Nurse) confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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: (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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and interview, the infection control committee failed to ensure an employee health program to determine the communicable disease history for 4 of 22 (N8, N22, N23 and N25) personnel files reviewed.</p>	S 0606	Prior to 2010, we did not require the current recommended communicable disease history or immunity documentation for new employees. We have completed our audit of all the employee health records for confirmation of evidence of immunity or lab confirmation of disease. If an employee was found to lack	10/07/2016

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	<p>Findings:</p> <p>1. Policy #934253, Associate Health Service, revised/reapproved 6/14 indicated on pg.:</p> <p>A. 1, under Pre-Placement Physical Exam section, the pre-placement physical examination completed at MedOne will require (as a condition of employment) the following...Laboratory tests: Rubella, Rubeola, Mumps and Varicella titers, Quantiferon TB or chest x-ray when appropriate.</p> <p>B. 3, under Associate Health Records section, a 'Permanent Health Folder' includes but is not limited to: Pre-placement medical questionnaire, physical examination record, laboratory and radiology findings, test results, immunization records, results of visits to Health Services, and Hepatitis B consent/declination form.</p> <p>2. Policy #861543, Immunizations, revised/reapproved 6/14 indicated on pg. 1, under Chickenpox Vaccine (Varicella) section, evidence of immunity includes documentation of 2 doses of varicella vaccine given at least 28 days apart, lab evidence of immunity, or lab confirmation of disease.</p> <p>3. Review of personnel files confirmed personnel:</p>		<p>documentation of disease or immunity, they have or will receive a lab requisition and a letter stating they have 30 days to comply to avoid suspension. If the lab results require a vaccine, then the employee will have 30 days to obtain the vaccine. All new employees will be required to have the recommended immunity documentation upon hire. Regarding contingency workers, a spreadsheet has been created and sent to company directors to log current health immunity requirements. The director must sign off and return the log verifying the listed workers have been audited and are compliant. For an ongoing process, a logsheet will be sent monthly to the directors of each contacted company containing new hires and will require the signature of verification. The Director of Human Resources is responsible.</p>	

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	<p>A. N8 (Licensed Practical Nurse) was hired on 1/03 and lacked documentation of communicable disease history or immunity to Rubeola.</p> <p>B. N22 (Director of Environmental Services [EVS]) was hired on 2/12 and lacked documentation of communicable disease history or immunity to Rubeola.</p> <p>C. N23 (EVS) was hired on 10/11 and lacked documentation of communicable disease history or immunity to Hepatitis B.</p> <p>D. N25 (Power Plant Mechanic) lacked documentation of communicable disease history or immunity to Hepatitis B.</p> <p>4. Staff N40 (Executive Director of Human Resources) and N42 (Director of Quality and Infection Control) were interviewed on 4/6/16 at approximately - -1100 hours, and confirmed the above-mentioned personnel lacked documentation of immunization and/or communicable disease history of Rubeola and Hepatitis B as required per facility policy and procedure.</p>			
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