

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2013
NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1373 EAST SR 62 MADISON, IN 47250		
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005063</p> <p>Dates: 02-18-13 through 2-20-13</p> <p>Surveyors: Billie Jo Fritch RN, MBA, MSN, FNP-C Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>QA: clauglin 02/22/13</p>	S000000			

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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S000406	<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>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include four (4) services in the facility's Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Review of facility's QAPI documents on 2-19-13 and 2-20-13 indicated lack of evidence that the services of biohazardous waste, tissue transplant, EEG, and the sleep lab were included in the facility's QAPI program.</p> <p>2. Interview with B#10 on 2-20-13 at 1125 hours confirmed that the services of biohazardous waste, tissue transplant, EEG, and the sleep lab are not included in the facility's QAPI program.</p>	S000406	<p>02/25/13 Quality Director and respective Department Directors (Cardio-vascular Services, Environmental Services and Surgical Services) were advised of QA/PI deficiency. Biohazard waste, Sleep lab, EEG and Tissue Transplant will be included in the facility wide QA/PI program. For example, the Sleep lab currently monitors impedance monthly and will begin reporting this information quarterly to the Quality Council. EEG monitoring for electrode placement (decrease impedance) will be implemented 03/01/13 and reported on 2 nd /3 rd quarter. Surgical services will monitor and report quarterly availability of the product and maintenance of shipping temperature.</p>	03/01/2013			

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S000554	<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 and staff interview, the facility failed to remove outdated supplies from 1 of 1 pediatric crash cart and 2 of 2 surgery department crash carts.</p> <p>Findings include:</p> <ol style="list-style-type: none"> During tour of the emergency department at 10:25 a.m. on 2/19/13, the following outdated supplies were found in the pediatric crash cart: <ul style="list-style-type: none"> (A) Six (6) I.V. delivery module packages with an expiration date of 9/12. During tour of the surgery department at 10:40 a.m. on 2/19/13, the following outdated supplies were found in 2 of 2 crash carts. <ul style="list-style-type: none"> (A) One (1) Bone injection gun with an expiration date of 6/12 was observed in the surgery crash cart. (B) One (1) Bone injection gun with an expiration date of 6/12 as well as one (1) arterial blood sample kit with an expiration date of 12/11 was observed in the post anesthesia care unit crash cart. 	S000554	<p>02/25/13 Nursing directors were advised of deficiency. Plan drafted. Department Directors (or their designee) will audit all code cart inventories monthly for a minimum for 6 months and until we see improvement, ensuring supplies are not outdated. Results of the audits will be recorded monthly and reported quarterly to the Quality Council. (02/23/13), all crash carts were inventoried, outdates discarded and supplies replaced. S 554y. Plan drafted, logs revised and assigned PM shift responsibility for inventory management. Department Directors (or their designee) will audit all code carts monthly for a minimum for 6 months and until we see improvement, ensuring supplies are not outdated. Results of the audits will be recorded monthly and reported quarterly to the Quality Council. Following the ISDH's departure and in preparation for our patient move (02/23/13), all crash carts were inventoried, outdates discarded and supplies replaced. 02/25/13 Nursing directors were advised of</p>	02/23/2013			

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	<p>3. Staff member #8 verified the E.D. supplies listed above were outdated at the time of tour.</p> <p>4. Staff member #9 verified the surgery department supplies listed above were outdated at the time of tour.</p>		deficienc		

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(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 blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for three of ten patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 2/18/13 at 1:00 p.m., review of policy, " Blood/Blood Products, Administration of", revised 3/11, read: "Review physician instructions and obtain patient signature on Consent for Transfusion of Blood or Blood Products. ...complete the documentation in the transfusion reaction section of the Blood Transfusion and Reaction Record." 2. On 2/18/13 at 1:00 p.m., review of three patients receiving blood units revealed three of these received-units did 	S000952	00/25/13 Nursing Directors were advised of deficiency. Plan drafted. Department Directors (or their designee) will audit each blood transfusion sheet and blood consent indefinitely, ensuring thorough and timely completion of documentation. Process will include the RN reviewing the transfusion sheet with the Shift Coordinator, Charge Nurse, Nursing Supervisor or Department Director prior to returning to the lab. The Blood Bank coordinator will also provide a second review of the transfusion sheets, report monthly and forward quarterly to the Quality Council.	02/25/2013			

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	<p>not have complete documentation, per policy, on the Blood Transfusion and Reaction Record sheet including:</p> <p>Patient #6 --Unit was administered on 2/09/13 at 1445: The question "Was there a possible transfusion reaction?" was answered as 'Yes'; however, the unit was completed at 1510 without a reaction noted. Vitals were each witnessed as within acceptable limits.</p> <p>Patient #7 --Unit was administered on 2/06/13 at 1154: While the unit was administered on 2/06/13, the consent was obtained 1 day later on 2/07/13 and without a witness signature.</p> <p>Patient #10 --Unit (only 1 letter in unit# was listed) was administered on 2/06/13 at 1650: The question "Was there a possible transfusion reaction?" was not answered.</p> <p>3. On 2/18/13 at 1:00 p.m., staff member #5 acknowledged the above-listed missing documentation.</p>			