

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2013
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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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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 006106</p> <p>Survey Date: 5-28/30-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 06/11/13</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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S000308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(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:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the hospital failed to orient 3 of 9 employees to applicable department policies, per facility policy.</p> <p>Findings:</p> <p>1. Review of Policy Number H-ML 11-001, entitled HOSPITAL WIDE EDUCATION PLAN, revised 02/2012, indicated department specific orientation is achieved in collaboration with appropriate department director/designee.</p> <p>2. Review of 9 personnel files indicated files PF#5, PF#6, PF#8 did not contain any documentation of specific department orientation.</p> <p>3. In interview, on 5-30-13 at 1:10 pm,</p>	S000308	<p>Immediate Corrective Action: Rehab Director notified of the need to ensure all staff (new and current) need to have documentation in employee files that demonstrates specific department orientation. The corporate office was contacted by Rehab Director in an attempt to locate the missing documentation. All 3 employees with missing documentation have been with the company for a number of years and were employed prior to department becoming a contract department. Director stated orientation was performed; however documentation not available.</p> <p>Further Corrective Action to prevent Recurrence: Rehab Director is auditing entire</p>	06/28/2013			

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	employee #A2 confirmed the above and no other documentation was provided prior to exit.		<p>department's personnel files to verify that department specific orientation is present. Those found to be lacking will receive department specific orientation no later than 6/28/13. Following completion of department specific orientation, documentation will be placed with each newly completed department specific orientation that states due to identified lack of compliance with department specific orientation available upon request, orientation was re-performed and documentation placed in employee files to ensure compliance with all regulatory bodies since original documentation cannot be produced.</p> <p>Monitoring: Rehab Director will ensure all new hires receive department specific orientation and ensure that documentation is present in files. Any identified non-compliance will be reported through Patient Safety / Clinical Services, Quality Council, Medical Executive Committee and Governing Board meetings.</p> <p>Responsibility: Rehab Director</p>		

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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, document review and interview, the facility failed to provide a safe environment by improperly storing nutrition feeding products that minimizes risk to patients on 2 of 3 inpatient units and failed to ensure clean and soiled items were not stored in the same area..</p> <p>Findings include:</p> <p>1. On 05-28-13 at 1135 hours on the West inpatient unit the following was observed in a lighted room on open shelves: 19 containers of Jevity 1.2 nutrition feeding that indicated the following on the manufacturer's label; "Contains light sensitive nutrients". 4 containers of Osmolite 1 cal nutrition feeding that indicated the following on the manufacturer's label; "Contains light sensitive nutrients". 8 containers of Pulmocare that indicated the following on the manufacturer's label; "Protect from light during storage". 8 containers of Glucerna 1.2 cal that</p>	S000554	<p>Immediate Corrective Action: #s 1, 2, 3 & 4) Feedings on both the East wing and West wing were placed in temporary storage containers to protect them from light pending cabinetry construction completion.</p> <p># 5) The paper towel packages stored on an open shelf in the housekeeping storage closet were removed and stored in a clean room to prevent contamination</p> <p>Further Corrective Action to prevent Recurrence: #s 1, 2, 3 & 4) Cabinetry has been installed to permanently store the feedings on East and West wing to protect them from light exposure. Permanent cabinetry was installed and feedings transferred to cabinets on 6/27/13.</p> <p># 5) Housekeeping staff notified that paper towels cannot be stored in the housekeeping storage closet due to the potential for contamination. Paper towels</p>	06/27/2013			

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	<p>indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>8 containers of Vital AF 1.2 cal that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>8 containers of Nepro that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>2. On 05-28-13 at 1340 hours on the East inpatient unit the following was observed in a lighted room on open shelves:</p> <p>8 containers of Osmolite 1 cal nutrition feeding that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>8 containers of Promote that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>8 containers of Glucerna 1.2 cal that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>8 containers of Perative that indicated the following on the manufacturer's label; "Contains light sensitive nutrients".</p> <p>3. Review of the manufacturer's guidelines for Abbott Nutrition nutrition products for avoiding light exposure indicated the following; "Store product in the shipper as long as possible or store on</p>		<p>now stored in a clean area.</p> <p>- Monitoring: Feeding storage and housekeeping storage closets will be monitored monthly during EOC (Environment of Care) and Infection Control rounds to ensure compliance maintained. Results will be reported through Infection Prevention & Control, Quality Council, Medical Executive Committee and Governing Board meetings through the end of 2013 to ensure compliance maintained. This monitoring will then be re-evaluated to determine whether monitoring needs to continue.</p> <p>- Responsibility: Infection Prevention Nurse</p>		

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	<p>covered shelves or in a closed cabinet prior to use."</p> <p>4. On 05-28-13 at 1135 hours, staff #40 confirmed that the nutrition products used to be stored in closed cabinets.</p> <p>5. On 5-28-13 at 11:45 am in the presence of employee #A5, it was observed in a housekeeping storage closet there were 18 packages of paper handtowels stored on an open shelf. It was also observed the ends of the packages were open to the room and not protected by some means. It was also observed there was a mop bucket, a slop sink, mops, a cleaning cart and cleaning supplies in close proximity to the towels. Because of the exposed ends of the packages and the close proximity of the packages to potential contamination, this presented an infection control issue.</p>			

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the facility failed to ensure that biological indicators were used at least once every 7 days for 1 of 1 steam sterilizer.</p> <p>Findings include;</p> <p>1. Review of 410 IAC 1-4-8 Precautions indicates the following; That biological indicators were used within seven (7) days prior to the current sterilization procedure.</p> <p>2. Review of policy/procedure G.30, Use of the Steam Sterilizer, indicated the following; "b) Process monitors, such as biological indicators and chemical indicators, should</p>	S000596	<p><u>Immediate Corrective Action:</u> The company was contacted regarding Biologicals needed for Midmark M 11 Autoclave Steam Sterilizer and Biologicals ordered. Autoclaving on the sterilizer was stopped pending the receipt of Biologicals and ran on the unit.</p> <p><u>Further Corrective Action to prevent Recurrence:</u> Biologicals have been received; manufacturer recommendations and policy will be followed for running Biologicals. Staff members that will be responsible for ensuring Biologicals are ran correctly has been educated on correct process. Staff members include Special Procedures</p>	06/26/2013	

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	<p>be included in each sterilization cycle." This policy/procedure was last reviewed/revised on 01-01-13.</p> <p>3. During the facility tour on 05-28-13 at 1455 hours a Midmark M11 Ultraclave Steam Sterilizer was observed in the clean work room.</p> <p>4. On 05-28-13 at 1455 hours staff #40 confirmed that the sterilizer is being used and no biologicals were being used.</p>		<p>Nurse, Nurse Manager and Chief Clinical Officer. Education completed on 6/26/13.</p> <p>- Monitoring: Biological reporting will be presented through appropriate committee meetings, EOC (Environment of Care), Infection Prevention & Control, Quality Council, Medical Executive Committee and Governing Board. Monitoring will be a standing item for reporting.</p> <p>- Responsibility: Infection Prevention Nurse</p>		

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on document review and observation, the facility failed to maintain hot holding of 135 degrees Fahrenheit or above while displayed on the Cafeteria serving line and the Kitchen Diet Serving Line for patients, staff, and guess as defined in 410 IAC 7-24-187,</p>	S000610	<p><u>Immediate Corrective Action:</u> Dietary staff immediately notified of the need to ensure that hot food temperature are maintained at 135 degrees Fahrenheit.</p> <p><u>Further Corrective Action to prevent Recurrence:</u> Hot food temperatures are to be checked, recorded and reported through appropriate</p>	05/30/2013

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	<p>Retail Food Establishment Sanitation Requirements and per hospital policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Kindred Hospital Food Temperature Cooking, Holding, and Point of Service policy #H-HS 04-013 (last approved 8/2012) states, "It is Kindred's policy to prepare and serve food at appropriate temperatures per federal, state, and city food regulations. All hot foods holding temperatures shall registered 135 degrees Fahrenheit or higher." Retail Food Establishment Sanitation Requirements 410 IAC 7-24-287 states, "Except during preparation, cooking, or cooling, potentially hazardous food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above" At 11:30 AM on 5/28/2013, the sliced beef roast on the cafeteria 		<p>committee meetings. Prior to placing food on food line, temperatures will be checked to ensure appropriate temperature is achieved.</p> <p>- Monitoring: The Director of Food Services will monitor temperature logs to ensure compliance and results will be reported through committee meetings; Infection Prevention & Control, Quality Council, Medical Executive Committee and Governing Board. This will be a standing report item.</p> <p>Responsibility: Food Service Director</p>	
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	<p>serving line registered between 119 and 121 degrees Fahrenheit. The hot seasoned egg noodles on the cafeteria serving line registered 117 degrees Fahrenheit.</p> <p>4. At 11:45 AM on 5/28/2013, the sliced beef roast on the diet serving line in the kitchen registered 117 degrees Fahrenheit.</p>			

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S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to ensure that there was evidence of informed consent for blood products prior to administration for 3 of 5 medical records (MR) reviewed (Patient #4, 5 and 7).</p> <p>Findings include:</p> <p>1. Review of patient #4's MR indicated the patient received a unit of packed red blood cells on 02-18-13 at 2030 hours. Review of the patient's General Consent for Administration of Blood Products indicated that consent was given for platelets.</p> <p>2. Review of patient #5's MR indicated the patient received a unit of packed red blood cells on 01-15-13 at 0239 hours. Review of the patient's General Consent</p>	S000754	<p>Immediate Corrective Action: Staff education provided regarding the need to ensure consent accuracy and completeness to include the type of blood product to be administered and that there are to be no blanks on consent form.</p> <p>Further Corrective Action to prevent Recurrence: The need to ensure consent accuracy and completeness was reviewed with physician's during May 31, 2013 Medical Executive Committee meeting. All blood units will be monitored to ensure accuracy of consents.</p> <p>- Monitoring: Audit results will be reported monthly through committee meetings; Patient Safety / Clinical Services, Quality Council, Medical Executive Committee and</p>	06/07/2013

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	<p>for Administration of Blood Products indicated that the proposed blood products to be administered was blank.</p> <p>3. Review of patient #7's MR indicated the patient received a unit of packed red blood cells on 03-07-13 at 0945 hours. Review of the patient's General Consent for Administration of Blood Products indicated that the proposed blood products to be administered was blank.</p> <p>4. On 05-30-13 at 1020 hours, staff #40 confirmed the General Consent for Administration of Blood Products should include the type of blood product to be given.</p>		<p>Governing Board.</p> <p>Responsibility: Director Quality Management</p>		

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S001114	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1)</p> <p>(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:</p> <p>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on observation, the hospital created 1 condition which was conducive to the harborage of insects</p> <p>Findings:</p> <p>1. On 5-28-13 at 11:40 am in the presence of employee #A5, it was observed on the outside of the hospital, there were 2 large storage containers for fuel for the the boiler and back-up generator. Surrounding the tanks, was a concrete apron approximately 1 foot high. There was approximately 3 feet between the tanks and the apron. It was also observed there was a standing pool of water approximately 4 inches deep within the area bounded by the apron. It was also observed there was some type of substance floating on top of the water.</p>	S001114	<p>Immediate Corrective Action: Water was immediately removed from the area identified</p> <p>Further Corrective Action to prevent Recurrence: State of Indiana was contacted for recommendations to prevent harboring / breeding of insects. The recommendation received was to utilize Inset Control Biscuits on a continual basis to prevent insect harboring.</p> <p>Monitoring: Insect Control Biscuits will be monitored during daily Plant Operations rounds and replaced as needed. Insect Control Biscuit in place has been added to Plant Operations daily rounds log. Results will be reported through appropriate committees; Environment of Care, Quality Council, Medical Executive</p>	06/19/2013

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	<p>2. In interview at the above date and time, employee #A5 indicated there was no method by which the pooled water was drained, pumped out or chemically treated.</p> <p>3. The standing water thus could serve to harbor/breed insects since it could remain pooled for several days if not drained or treated chemically shortly after it collected water.</p>		<p>Committee and Governing Board. This will be a standing report item.</p> <p>Responsibility: Director Plant Operations</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2013
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 W 10TH ST INDIANAPOLIS, IN 46222		
(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	
S001164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(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:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. On 5-28-13 at 11:15 am, employee #A5 was requested to provide documentation of PM on a food processor and a hand/shoulder exerciser, Model# 18010. Both items were located in the Occupational Therapy area.</p> <p>2. In interview, on 5-28-13 at 3:30 pm, employee #A5 indicated there was no documentation and none was provided prior to exit.</p>	S001164	<p>Immediate Corrective Action: Biomed was contacted to perform PM on hand / shoulder exerciser. The food processor was removed from the facility. This was an employee's property that was brought in for another staff member.</p> <p>Further Corrective Action to prevent Recurrence: Hand exerciser was had PM performed on 6/20/13. This item has been added to the PM schedule to ensure compliance with PM's maintained.</p> <p>- Monitoring: Director of Plant Operations will review Biomed log and report to ensure all items identified and PM performed as required. Reports submitted through EOC (Environment of Care, Quality Council, Medical Executive Committee and Governing Board.</p>	06/20/2013	

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			Responsibility: Director Plant Operations	