

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150176	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2013
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NAME OF PROVIDER OR SUPPLIER KENTUCKIANA MEDICAL CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 011788</p> <p>Dates: 3-4-13 through 3-5-13</p> <p>Surveyors: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>QA: claughlin 03/12/13</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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S000270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing body failed to review the reports of management operations that included Quality Assurance and Performance Improvement (QAPI) reports, for 3 of 4 quarters (1st, 2nd, and 4th quarters) in 2012.</p> <p>Findings included:</p> <p>1. Review of facility documents on 3-5-13 indicated governing body meetings were held on 3-30-12, 6-29-12, 9-4-12, 9-11-12, and 10-30-12; documentation indicated a QAPI report was provided to the governing body only at the 9-4-12 meeting (3rd quarter of 2012).</p> <p>2. An interview was conducted with B#3 on 3-5-13 at 1145 hours and confirmed QAPI information was provided to the</p>	S000270	S 0270: Deficiency Corrected: Deficiency was corrected on 03/26/2013. Please find attached the Board Meeting minutes of March 26, 2013 where the Quapi minutes from their meeting of January 24, 2013 was reviewed. Plan of Action: The QUAPI Report will be reviewed Quarterly by the Board of Managers. The Board of Managers meeting is set for the third month of each quarter. Responsible: Chief Nursing Officer will be responsible for ensuring the QUAPI plan is followed and reported via that committee and the Chief Executive Officer will ensure Quarterly Board Meetings are held and the minutes reviewed.	03/26/2013

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	governing body at the 9-4-12 meeting and none is documented as provided/discussed during the 1st, 2nd, or 4th quarters of 2012.			

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S000312	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the governing body failed to ensure a performance evaluation was conducted/provided for 1 of 7 (P#3) employees.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of personnel records on 3-4-13 lacked evidence that P#3, hired 7-30-10, had a performance evaluation conducted, provided, or documented since they were hired in 2010. 2. An interview was conducted on 3-4-13 at 1630 hours with B#4 who confirmed that P#3, hired 7-30-10, has never had a performance evaluation and the facility requires annual performance evaluations for all employees. 	S000312	S 0312: Deficiency Corrected: The missing performance evaluation was completed on March 11, 2013. Plan of Action: The Manager Human Resources is reviewing all files to ensure this error has not repeated itself. Manager, Human Resources has implemented a tickler system to have a performance evaluation completed on the anniversary of the staff members employment annually. Responsible: Manager, Human Resources will be responsible for completion of this requirement and the Chief Operating Officer is tasked with oversight to ensure compliance.	03/11/2013	

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the governing board failed to enforce the facility policy requiring Cardiopulmonary Resuscitation (CPR) competency for 10 of 11 physicians (MD's# 1, 2, 3, 4, 5, 6, 7, 8, 10, and 11) as indicated by physician credential file review.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of physician credential files on 3-4-13 lacked evidence that 10 of 11 physicians (MD's# 1, 2, 3, 4, 5, 6, 7, 8, 10, and 11) had documented competency in CPR in their credential files as required by facility policy. 2. Review of facility policy titled CPR 	S000318	S 0318: Deficiency Corrected: KMC Policy MS 1.19 was revised and attached for your review. The new policy was reviewed and approved by the Board of Managers on March 26, 2013. Plan of Action: All new staff members credentialed after this date will meet this policy. All currently credentialed staff members' files are being reviewed and will be updated to meet this standard. The expectation of completion of this review is April 13, 2013. Responsible: The Medical Staff Office will responsible to meet this task and the Chief Operating Officer is task to ensure compliance.	04/13/2013			

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	<p>COMPETENCE, MEDICAL STAFF, most recently updated on 9-11-12, on 3-5-13 indicated the following: To ensure competence, all employed, contracted, and /or designated medical staff practitioners who provide direct patient contact and care shall provide proof of cardiopulmonary resuscitation competence. This shall include the following designated specialties, anesthesiology, emergency medicine, cardiology, cardiothoracic surgery, and radiology. Documentation of CPR competence will be kept on file in Medical Staff Services for the following: acceptable proof of competency shall include Basic Life Support (BLS) and/or Advance Cardiac Lie Support (ACLS).</p> <p>3. An interview was conducted with B#7 on 3-5-13 at 1055 hours and confirmed the facility policy requires all physicians to provide proof of CPR competency, either BLS or ACLS certification, per facility policy approved 9-11-12. B#7 confirmed 10 of 11 physicians, MD's #1, 2, 3, 4, 5, 6, 7, 8, 10, and 11, lacked evidence of competency in CPR by BLS or ACLS certification as required by facility policy.</p>				

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S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on facility document review and staff interview, the hospital failed to document annual employee infection control and fire life safety information for eight (#'s 1 to 7 & #9) of ten eligible personnel files. Findings included: 1. On 3/05/13 at 12:30 p.m., review of 8 (#'s 1 to 7 & #9) personnel files failed to contain infection control and fire life safety information training. 2. On 3/05/13 at 12:30 p.m., employee #4 acknowledged the above-listed missing documentation.</p>	S000330	S 0330: Deficiency Corrected: The missing folder has not been located by Human Resources. However the staff members with deficiencies as noted on the survey have completed the required training and education in both areas. Plan of Action: All employee folders are being reviewed to ensure complete compliance of this standard. Manager, Human Resources has a tickler system in place to review all requirements upon the annual anniversary of the employee hiring date. Responsible: Manager, Human Resources will be responsible for the compliance of this standard and the Chief Operating Officer will be	03/26/2013			

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			responsible for oversight.	

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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 staff interview and document review, the facility failed to ensure high level disinfectant was used according to manufacturers recommendations for 1 surgery department toured.</p> <p>Findings include:</p> <p>1. Instrument tech #1 indicated the following in interview at 10:55 a.m. on 3/5/13: (A) He/she tests the Cidex OPA solution on a daily basis and not with each use. (B) The (+) marked on the "Cidex OPA Cleaning Log" for each scope that is processed is based on the daily check.</p> <p>2. The package insert for Cidex OPA stated "It is recommended that CIDEX</p>	S000596	S 0596: Deficiency Corrected: Testing on Cidex OPA solution will occur before each use, beginning date: Please see attached "Cidex OPA Cleaning Log."Plan of Action: Testing of Cidex solution will occur each day and before each use.Responsible: Manager, Operating Room will ensure compliance and the Chief Nursing Officer will have oversight.	03/11/2013

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	<p>OPA solution be tested before each usage with the CIDEX OPA Solution test strips in order to guard against dilution, which may lower the ortho-phthalaldehyde level of the solution below its MEC of 0.3%."</p> <p>3. Facility policy titled "Endoscopes" last reviewed/revised 9/4/12 stated on page 1 under policy: "An EPA-registered liquid cold sterilant or disinfectant solution will be utilized for all endoscopes and compatible accessories in accordance with established procedure and following the manufacturer's guidelines....."</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 observation and staff interview, the facility failed to ensure microwaves were used only for food preparation for 1 of 3 units toured.</p> <p>Findings include:</p> <p>1. During tour of the transitional care unit beginning at 9:30 a.m. on 3/5/13, a heat pack wrapped in a pillowcase was</p>	S000610	S 610: Deficiency Corrected: Heat Pack and Pillow case immediately removed from Microwave. Correction and Plan of Action: Surveys of environmen will be conducted on a weekly basis and include nutrition area and microwaves use for food preparation only. The Infection Control Committee will review environmental audits and recommedn changes in	03/11/2013

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	<p>observed in the microwave in the nutrition area.</p> <p>2. Staff member #N2 indicated at the time of the observation that he/she did not know what patient the heat pack belonged to or who put it in the microwave.</p>		<p>procedures, policies and programs as needed. See attached audit tool. Responsible: Infection Control Practitioner, Managers and Chief Nursing Officer will be responsible for compliance to this standard.</p>		

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S000744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and staff interview, the facility failed to ensure the patient's signature was obtained on discharge instructions for 5 of 11 patients (patients #3, 7, 8, 9, and 13).</p> <p>Findings include:</p> <p>1. Facility policy titled "Routine Patient Dismissal" last reviewed/ revised 9/10/12 stated on page 2: "2. Provide pre-printed home instruction sheet, and discharge medication reconciliation form, and review with patient and/or significant other. * Responsible person will sign instruction sheet which signifies he/she understands these instructions....."</p> <p>2. Patients #3, 7, 8, 9, and 13 medical records lacked a patient's signature on the discharge instruction sheets. The signature section was blank.</p> <p>3. Staff member #3 verified the above at 2:00 p.m. on 3/5/13.</p>	S000744	S 0744: Correction and Plan of Action: Nurses will ensure patient signs discharge instruction form during discharge process, they will then place a copy on patient chart, and give a copy to the patient to take home. Please see attached audit of this process. Responsible: Nursing Managers of the units will be responsible to ensure staff members have patients sign discharge instructions to comply with this standard. The Chief Nursing Officer will be responsible for oversight of compliance.	03/26/2013

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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 procedure for one (Patient #5) of ten patients.</p> <p>Finding(s) include:</p> <p>1. On 3/4/13 at 1:00 p.m., review of the policy, "Blood and Blood Product Administration", reviewed July 2009, read: "If a transfusion reaction is suspected, see the procedure "Nursing Protocol for Transfusion Reaction" for specific instructions."</p> <p>2. On 3/4/13 at 1:00 p.m., review of the policy, "Nursing Protocol for Transfusion Reaction", reviewed July 2009, read: "Symptoms of a suspected transfusion reaction include but not limited to:</p>	S000952	<p>S 0952: Deficiency Corrected: The nurse managers conducted staff meetings to discuss blood transfusion process and documentation of possible transfusion reactions. Plan of Action: Manager, Laboratory Services, Chief Nursing Officer/Infection Control Officer will meet monthly to review blood transfusion forms and ensure all errors have been found. Responsible. Manager, Laboratory Services and Chief Nursing Officer will be responsible for oversight and compliance of this standard.</p>	03/19/2013			

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	<p>Elevated temperature of 2 degrees Fahrenheit (F) or more</p> <p>Notify the physician. Notify the lab."</p> <p>3. On 3/04/13 at 1:00 p.m., review of one patient's vital record indicating a received blood unit, revealed this received-unit did not have complete documentation, per policy, on the Blood Transfusion Record form including:</p> <p>Patient #5</p> <p>--Unit administered on 2/15/13 at 2230:</p> <p>The pretransfusion temperature was 96.5 F and the final finish temperature was 98.7 F. The temperature difference was 2.2 degrees F.</p> <p>4. On 3/4/13 at 1:00 p.m., staff member #5 acknowledged that the above-listed patient had received blood without benefit of complete documentation, per policy, as required.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150176		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/05/2013	
NAME OF PROVIDER OR SUPPLIER KENTUCKIANA MEDICAL CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129			
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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</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>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the facility maintained a condition which could result in a hazard to hospital staff.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the plant operations department at the hospital on 3-5-13 at 0920 hours with P#4, it was observed that the area where water testing is conducted using caustic chemicals, lacked an eye wash in the department. 2. An interview was conducted with P#4 on 3-5-13 at 0920 hours, who confirmed that there is no eye wash in the department where water testing is conducted with the use of caustic chemicals. 	S001118	S 1118: Deficiency Corrected: Eye watch station purchased and installed March 20, 2013. See attached documentation. Plan of Action: As above. Manager, Plant Properties will survey campus to ensure no other deficiencies of this kind exist. Responsible: Manager, Plant Properties will be responsible for compliance of this standard and The Chief Operating Officer will have oversight.	03/20/2013			

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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 facility failed to conduct preventative maintenance (PM) for 7 pieces of equipment (C-arm, dietary ovens, emergency nurse call system, CT scanner, ultrasonography machine, portable x-ray machine, and fluro-radiology) to ensure patient and staff safety as required by facility policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 3-5-13 indicated the following: <ol style="list-style-type: none"> a. The most recent PM for the C-arm is documented as 7-16-10. b. The most recent PM for the CT scanner is documented as 3-10-11. c. The most recent PM for the portable X-ray machine is documented as 6-10-10. d. The most recent PM for the Fluro X-ray machine is documented as 6-4-10. 	S001164	S 1164: Deficiency Addressed: Kentuckiana Medical Center has contracted with Bluegrass Biomedical, Inc. for Preventative Maintenance on Biomedical Equipment. They have provided one inspection. Please see attached documentation and will continue monthly to ensure all equipment is in an "A" status. Toshiba has been contacted and their technician will be on board March 29, 2013 to perform a PM on the CT. The remaining equipment will be under contract with Interstate Imaging. Please see attached quotes that are being reworked and will be funded. All equipment has undergone a safety inspection to ensure there are no safety hazards. Emergency Call system has been tested and placed on an annual inspection plan as well as the Dietary ovens. Plan of Action: As above Responsible: Manager, Plant Properties will be	04/12/2013	

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	<p>e. The most recent PM for the ultrasonography machine is documented as done with replacement in March 2010.</p> <p>f. There is no documentation of PM for the dietary ovens or the emergency nurse call system.</p> <p>2. Review of facility policy titled EQUIPMENT INSPECTION PROGRAM on 3-5-13, most recently updated 9-4-12, indicated the following: All equipment purchased/utilized by the hospital will be scheduled for periodic inspection with a scheduled testing interval of 12 months or less.</p> <p>3. Review of facility policy titled TESTING AND REPORTING on 3-5-13, most recently updated 9-25-12, indicated the following: The Radiology Manager shall schedule preventative maintenance every twelve months.</p> <p>4. Review of facility policy titled EQUIPMENT MANAGEMENT on 3-5-13, most recently updated 9-4-12, indicated the following: Regularly scheduled inspections of equipment will be done to insure compliance with safety standards and insure that our patients and employees are working in a safe environment.</p> <p>5. An interview was conducted with B#9 on 3-5-13 at 1150 hours and confirmed the following:</p> <p>a. The most recent PM for the C-arm is documented as 7-16-10.</p>		responsible for compliance and the Chief Operating Officer will be responsible for oversight of compliance.				

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	<p>b. The most recent PM for the CT scanner is documented as 3-10-11.</p> <p>c. The most recent PM for the portable X-ray machine is documented as 6-10-10.</p> <p>d. The most recent PM for the Fluro X-ray machine is documented as 6-4-10.</p> <p>e. The most recent PM for the ultrasonography machine is documented as done with replacement in March 2010.</p> <p>6. An interview was conducted with P#4 on 3-5-13 at 1000 hours and 1210 hours, respectively, and confirmed there has been no documentation of PM done for the emergency nurse call system or the facility's dietary ovens.</p>			