STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

(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
S000000	This visit was for a State hospital licensure survey. Dates: 7/15/2014 through 7/17/2014 Facility Number: 008899 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: Claughlin 07/25/14	S000000		
S000270	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320	

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	(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. Based on documentation review and staff interview, the Governing Board failed to ensure quality review was reviewed quarterly for years 2013 and 2014. Findings included: 1. The 2013 and 2014 Governing Board Meeting minutes were reviewed. The Governing Board Meeting minutes provided revealed 2 meetings were held in 2013: May 29 and October 28. The Governing Board had two meetings for the first two complete quarters of 2014 (February 6 and March 7); however, the minutes provided for 2014 only were held in the first quarter. The two meeting minutes held in the first quarter of 2014 did not document any discussion of quality review. The two meetings held in 2013 had documented	S000270	**Tag: S270** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · The actual citation was sent Saturday, 7-26-14. The actual citation was received Monday, 7-28-14. · The governing board met on 7-18-14 to discuss the verbal findings provided at the close of the survey. · The governing board participants noted that going forward; o Governing board meetings will be held quarterly. o Quality review discussions will be done at each governing board meeting. o Quality review discussions done in governing board meetings will be documented in the minutes. **2. How are you going to prevent the deficiency from recurring in the future?** · Quarterly invites will be sent to governing board participants for quarterly meetings.	07/21/2014

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	evidence of quality review being discussed; however, the first and third quarter did not have a documented Governing Board meeting. Therefore, the Governing Board did not have documented evidence that quality review was discussed quarterly for 2013 and 2014. 2. At 10:30 AM on 7/17/2014, staff member #5, director of nursing, confirmed the Governing Board Meetings were not held quarterly in 2013; however, the meetings were scheduled quarterly for 2014. The staff member confirmed the meetings held in 2014 did not evidence quality review discussion.		· Quality review was added as a standing item on the agenda on 7-21-14. · Attendance and minutes will be taken at each meeting to include quality review discussions. ·Audits will be done on the next 3 governing board minutes to assure 100% compliance with quality review discussions. · Results of the quality review discussion audits will be given at the next 3 quality management meetings following the governing board meetings to assure 100% compliance is maintained. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The CEO. **4. By what date are you going to have the deficiency corrected?** · The deficiency was corrected 7-21-14.	
S000308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following:			

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	(6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on personnel file review, facility document review, and interview, the facility failed to ensure all staff received initial hospital and departmental orientation in 2 of 2 contracted agency nurses reviewed (C1 and C2). Findings included: 1. The personnel file for contracted agency nurse C1, with a hire date of 12/22/12, lacked documentation of any hospital or departmental orientation. 2. The personnel file for contracted agency nurse C2, with a hire date of 07/09/11, lacked documentation of any hospital or departmental orientation. The skills checklist provided by the agency indicated several areas "No Training or Experience" for nurse C2, including cardiac telemetry, medications, starting IVs (intravenous), and ventilator care. All of these procedures/treatments were provided to patients in the 2 units of the facility.	S000308	**S 308** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · The citation was sent Saturday, 7-26-14. The actual citation was received on Monday, 7-28-14. · On 7-21-14, the contracted agency was contacted and informed that contracted agency staff members C1 and C2 cannot work on the units until they have completed tangible hospital training and department orientation. · A skills checklist assessment will be completed and returned to HR on contracted agency staff C2, and active contracted agency staff to assure training in working with patients not limited to but including vents, starting IVs, cardiac telemetry, medications, etc. · On 7-30-14, a list of all contracted agency staff scheduled to work in the facility was sent to Human Resources (HR) Coordinator, Educator and the Employee Health Nurse.	08/15/2014

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	3. Facility documentation indicated nurse C1 last worked at the facility 07/03/14 and nurse C2 worked 07/03/14 and 07/04/14. 4. At 11:40 AM on 07/17/14, staff member A4, educator, confirmed the documentation provided was all the facility had on the agency nurses and confirmed the lack of any orientation to the facility or department.		· From the active list, initiation of mandatory hospital and departmental orientation was scheduled for contracted agency staff to attend the second week of each month beginning the week of 8-10-14. · Contracted agency staff that has completed hospital and departmental orientation will be provided to the Chief Clinical Officer (CCO), Nurse Manager, Agency, and Nursing Supervisors for scheduling. · Hospital and departmental orientation will be completed for current and all new contracted agency staff prior to working on the units. · Completed hospital and departmental orientation checklist will be returned to HR to place in active contracted agency personnel files. · Glucometer testing, annual training and house wide in-services will be provided to contracted agency for yearly management. (Confirmation of completion will be sent to HR for filing) · A new Contract Services Tracking and Reporting Tool for monitoring purposes was implemented on 7-24-14. · The new Contract Services Tracking and Reporting Tool will be reported monthly to the Patient Care and Safety/Quality Management Committee. · Completion of mandatory hospital and departmental orientation	

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			for active contracted agency staff was completed by 8-15-14. **2. How are you going to prevent the deficiency from recurring in the future?** · All active contracted agency staff must be cleared to work by HR, Education, and the Employee Health nurse. · On 7-30-14, an "Agency Clear to Work List" was created by the educator. · Contracted agency staff working in the facility on the 2 units must be chosen from the 'Agency Clear to Work List,' provided by the educator. · Assessment of contracted agency files were initiated 7-21-14 and will be done quarterly to assure compliance. · The Contracted Agency was added to the Contracted Services and Reporting Tool 7-24-14. · The Contracted Services and Reporting Tool will be monitored monthly, and discussed monthly in the Patient Care and Safety/Quality Management (QM) Committee meetings. · Random audits will be done minimally for 3 months of the Contracted Services and Reporting Tool to assure 100% compliance is maintained. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor,**	

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			etc.? · The CCO. **4. By what date are you going to have the deficiency corrected?** · August 15, 2014	
S000312	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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: (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.			
	Based on personnel file review, facility document review, and interview, the facility failed to ensure all staff received an annual performance evaluation based on a job description in 2 of 2 contracted agency nurses reviewed (C1 and C2). Findings included: 1. The personnel file for contracted agency nurse C1, with a hire date of 12/22/12, lacked documentation of any	S000312	**S312** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · The actual citation was sent Saturday, 7-26-14. The actual citation was received on Monday, 7-28-14. · An annual performance evaluation was initiated on 8-1-14 for contracted agency staff C1 and C2.	08/15/2014

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	evaluation or job description. 2. The personnel file for contracted agency nurse C2, with a hire date of 07/09/11, lacked documentation of any evaluation or job description. 3. Facility documentation indicated nurse C1 last worked at the facility 07/03/14 and nurse C2 worked 07/03/14 and 07/04/14. 4. At 11:40 AM on 07/17/14, staff member A4, educator, confirmed the documentation provided was all the facility had on the agency nurses and confirmed the lack of a job description or evaluation of their work performance in the facility.		· A copy of the job description for contracted agency C1 and C2 was given for review and signature on 8-1-14. · Completed annual performance evaluations will be returned to HR on active contracted agency staff. · Evaluations will be performed by nursing supervisor at the close of the agency staff's shift, and will be maintained yearly, or until the contracted agency staff, is no longer an active member of our agency list. · Competencies will be completed for all new contracted agency staff prior to working on the unit. · Initial evaluations will done on contracted agencies first 4 shifts of working, then annually to assure competency. · Completed competency checklist will be returned to HR to place in active contracted agency personnel files. · A copy of the job description for contracted agency/RNs will be provided to the agency for all active contracted agency staff to review and sign. · A copy of the job description will be forwarded to the HR Coordinator for review and placed in the contracted agencies staff personnel file. · The Contracted Agency was added to the Contracted Services and Reporting Tool 7-24-14. · The Contracted Services and Reporting Tool will be monitored	

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			and discussed monthly in the Patient Care and Safety/Quality Management (QM) Committee meetings. **2. How are you going to prevent the deficiency from recurring in the future?** · Contracted active agency staff is required to have evaluations prior to working at the facility. · Contracted agency staff must review and sign job descriptions prior to working at the facility. · Review of all contracted agency files was initiated 7-30-14 and completed 8-1-14. · Review of all contracted agency files will be done quarterly for evaluations and job descriptions to assure 100 % compliance in their HR files. · Contracted agency on the Contract Services Tracking and Reporting Tool will be monitored monthly. · Contracted agency on the Contract Services Tracking and Reporting Tool will be discussed monthly in Patient Care and Safety/Quality Management Meetings. · Random audits will be done minimally for 3 months of the Contracted Services and Reporting Tool to assure 100% compliance is maintained. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?**	

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			· The CCO. **1.By what date are you going to have the deficiency corrected?** · August 15, 2014	
S000322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on documentation review and staff interview, the Governing Board failed to ensure the hospital had a policy on maintaining safe operation on health care equipment used within the facility. Findings included: 1. The hospital policies and procedures were reviewed with staff member	S000322	**S322** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · The Lockout/Tagout Policy and Utilities Systems Management Plan were reviewed by the governing board on 8-6-14. · The Lockout/Tagout Policy was revised on 8-7-14 to include monthly/annual/manufacturers' recommendations for preventive maintenance on healthcare equipment in the department that	08/15/2014

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	#4, educator. Lockout/Tagout policy (last reviewed 8/2013) and Utility Systems Management Plan (last reviewed 3/2014) were the only facility policies that identified the maintenance procedures on hospital equipment. The Lockout/Tagout policy explained the procedures on maintenance of equipment after the equipment was not in working condition. The Utility Systems Management Plan covered processes of utilities system management. Neither policy identified the preventive maintenance of health care equipment. 2. At 10:45 AM on 7/17/2014, staff member #4 indicated the hospital does not have a policy for preventive maintenance on health care equipment in the hospital.		qualifies for the program. · The Utilities Systems Management Plan was revised on 8-7-14 to include annual/manufacturers' recommendations for preventive maintenance on healthcare equipment for the emergency power supply system. · The Medical Equipment Management Plan was revised on 8-7-14 to include annual/manufacturers' recommendations for preventive maintenance on healthcare equipment for healthcare/medical/patient healthcare equipment . · Healthcare equipment for the Lockout/Tagout Policy and Utilities Systems Management/Medical Equipment Plan was tagged to include monthly/annual/manufacturers' recommendation of PM dates. · The Lockout/Tagout Policy and Utilities Systems Management Plan will be reviewed and or revised annually to assure preventive maintenance is at 100% compliance. · Training for staff on preventive maintenance on the Lockout/Tagout Policy and Utilities Systems/Medical Equipment Management Plan was initiated for all shifts by the educator in huddles on 8-8-14 and completed on 8-15-14. **2. How are you going to prevent the deficiency from recurring in the future?**	

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			· Healthcare equipment that pertains to the Lockout/Tagout Policy and Utilities Systems Management/Medical Equipment Management Plan was added to the EOC monthly rounding form. · Monthly PM reports will be obtained monthly/annual/upon manufacturers' recommendation from the host. · The Lockout/Tagout and Utilities Systems/Medical Equipment Management healthcare equipment was added to the Contracted Services and Reporting Tool on 8-7-14. · The Contracted Services and Reporting Tool will be monitored and discussed monthly in the Patient Care and Safety/Quality Management (QM) Committee meetings. · Any healthcare equipment concerns/information will be reported to Environment of Care (EOC) and or Governing Board quarterly. · Initiation of documentation of education in the education tracker, LMS, for new and active employees began 8-11-14. · Random audits will be done minimally for 3 months of the Contracted Services and Reporting Tool to assure 100% compliance is maintained. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The CEO.	

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			1.By what date are you going to have the deficiency corrected? · 8-15-14	
S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure 4 services provided by contractors were part of the hospital's comprehensive quality assessment and improvement (QA&I) program: Ambulance, PICC Line Services, Laundry/Linen, and Security. Findings included: 1. Kindred Northwest Hospital	S000406	**S406** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · A new Contract Services Tracking and Reporting Tool was implemented on 7-24-14. · The new Contract Services Tracking and Reporting Tool will be reviewed and reported monthly in the Patient Care and Safety/Quality Management Committee Meetings. · Contracted services, including but not limited to, ambulance, environmental food services, plant operations, PICC line, laundry/linen,	08/15/2014

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	Quality Improvement Plan implements all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. Ambulance service agreement (signed May 2014) indicated the ambulance service will ensure the quality and appropriateness of customer care services provided are monitored and evaluated, and identified problems are resolved. The ambulance standards shall be available to the hospital for quality review. 3. Kindred Northwest Hospital and environmental, food service, and plant operations service agreement (signed September 2012) indicated Kindred Northwest Hospital was to monitor the safety and quality of Environmental, Food Service, and Plant Operations services provided. 4. Kindred Northwest Hospital failed to ensure 4 services provided		radiology, Bio Med, housekeeping, contracted nursing agencies, dialysis center, rehab care, environmental services, and security that may have direct or indirect impact on patient care was added to the Contracted Services Tracking and Reporting Tool on 8-1-14. · Contracted services that may have direct or indirect impact on patient care will be reviewed, monitored, evaluated and reported monthly at the Patient Care and Safety/Quality Management (QM) Meetings. · Contracted ambulance service will be monitored and evaluated monthly to assure quality and appropriateness of customer care services. · Ambulance standards will be reviewed monthly at Patient Care and Safety/Quality Management Committee Meetings. · Problems identified with all contracted services will be resolved within 30 days of the identified concern. · The Safety and Quality of Environmental Food Services and Plant Operations will be monitored and reported monthly in the Patient Care and Safety/Quality Management Committee Meetings. · Ambulance, PICC Line Services, Laundry/Linen, and Security were added to the Contract Services Tracking and Reporting Tool for monthly monitoring of agreed upon quality control indicators.	

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	by contractors wre part of the hospital's comprehensive quality assessment and improvement (QA&I) program: Ambulance, PICC Line Services, Laundry/Linen, and Security. The quality control defined in the contracted services agreements were not part of Kindred Northwest Hospital's quality control. 5. At 2:15 on 7/16/2014, staff member #5, director of nursing, confirmed the 4 contracted services (Ambulance, PICC Line Services, Laundry/Linen, and Security) were not monitored and evaluated as part of the hospital's quality improvement program.		· Ambulance, PICC Line Services, Laundry/Linen, and Security monitoring for agreed upon quality control indicators will be done monthly in the Patient Care and Safety/Quality Management Meetings. **2. How are you going to prevent the deficiency from recurring in the future?** · The Contracted Services Tracking and Reporting Tool was discussed with leadership 7-28-14. · Initiation of education of staff for compliance of reporting and documentation on the tracking tool was done 8-8-14 and completed 8-15-14 for all shifts. · The Contracted Services Tracking and Reporting Tool was added as a standard item on the Patient Care and Safety/QM agenda 8-6-14. · Auditing of the Contracted Services Tracking and Reporting Tool will be done minimally for 3 months to assure 100% compliance of the process is maintained. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The CCO. **1.By what date are you going to have the deficiency corrected?** August 15, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/17/2014

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S000556	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on policy and procedure review, personnel file review, and interview, the facility failed to ensure TB testing/screening was performed according to policy for 5 of 10 staff members (P1, P2, P4, P9, and P10). Findings included: 1. The facility policy "Employee Health Program", last revised 08/2013, indicated, "2. Prospective and current employees will undergo periodic health evaluations as required by local and State licensure requirements. These may include, but are not limited to, some or all of the following as described by State or Federal Law: ...c. Annual screening for tuberculosis based on annual TB Risk Assessment." 2. The personnel file for staff member P1, who was hired 12/07/95, indicated	S000556	**S556** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · On 7-18-14 calls were made for staff with incomplete files to come in for their PPD/CXR. · Active staff was informed beginning 7-21-14, that they must have PPD's repeated by their anniversary date each year, or they will not be able to work on the unit. **2. How are you going to prevent the deficiency from recurring in the future?** · Active staff records will be reviewed monthly for anniversary dates of their PPD. · Initiation of anniversary dates for staff began 8-6-14 and will be entered into our LMS system that will send reminders to department heads when PPD's are due. · Active staff must have their	08/15/2014

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	the last TB test was 09/12. 3. The personnel file for staff member P2, who was hired 05/13/02, indicated the last TB test was 04/13. 4. The personnel file for staff member P4, who was hired 01/09/13, indicated the last TB test was 12/12. 5. The personnel file for staff member P9, who was hired 03/27/12, indicated the last TB test was 03/12. 6. The personnel file for staff member P10, who was hired 03/22/11, indicated the last TB test was 06/12. 7. At 9:00 AM on 07/16/14, the Infection Control Preventionist/Employee Health Nurse, staff member A3, indicated the facility still performed annual TB testing on employees and it should be done around the employee's anniversary date.		PPD prior to working on the units. · Department heads will be notified monthly of staff compliance with PPD's. · Initiation of compliance rates will be reported in the EOC committee meetings beginning 8-6-14. · Monthly tracking will be done minimally for 3 months to assure 100% compliance is maintained. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The Employee Health/Infection Control Nurse. **1.By what date are you going to have the deficiency corrected?** · August 15, 2014	
S000762	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (13) A discharge summary			

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	authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.			
	Based on review of the Medical Staff Rules and Regulations, policy and procedure review, medical record review, and interview, the facility failed to ensure all medical records for patients hospitalized for greater than 48 hours contained a timely and authenticated discharge summary for 14 of 18 (N1, N2, N3, N5, N7, N8, N9, N10, N11, N12, N14, N15, N18, and N19) records reviewed of patients who were discharged over 30 days ago. Findings included: 1. The facility's Medical Staff Rules and Regulations, effective April 2012, indicated, "C. Medical Records: 1. The attending Physician shall be responsible for the preparation of a complete, accurate, timely, legible and verifiable medical record for each patient. ...This record shall include: ...g. a discharge summary to include conclusions at termination of hospitalization and final diagnosis, major complications and comorbid conditions that influenced the	S000762	**S762** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · Beginning 7-29-14 chart audits were done on medical records for the following, but not limited to, completion, accuracy, timeliness, legibility, verification, discharge summaries, final diagnosis, dates, death summaries, and authentication. · On 7-28-14 initiation of flagging incomplete medical records was done for each physician by color code. · Physician offices with incomplete medical records were contacted beginning 7-29-14 to arrange a time for record completion to include but not limited to discharge summaries and their conclusions at termination of hospitalization, final diagnosis, major complications and comorbidities that influence patient care/length of stay for all patients hospitalized over 48 hours. · Physician offices with medical records that were not completed within 30 days after	08/15/2014

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	patient's care or length of stay at least one day. ...14. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. ...15. ...A medical record must be completed within thirty (30) days after discharge and consists at a minimum of the following authenticated documents: ...k. Discharge Summary. 16. The attending Physician shall complete the medical record at the time of the patient's discharge, to include progress notes, final diagnosis, and discharge summary. ...27. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated." 2. The facility's policy "General Documentation Guidelines", last revised 08/2013, indicated, "7. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated and their authors identified. ...16. Discharge Summary: A discharge summary must be written or dictated and authenticated by the responsible physician on the medical record of hospitalized inpatients for stays over 48 hours. ...The time period for completion of the medical record is specified in the Medical Staff Rules and Regulations and cannot exceed 30 days after discharge." 3. The medical record for patient N1,		discharge were contacted beginning 7-29-14 to arrange a time for record completion of discharge summaries, progress notes to include final diagnosis, accurate dates and times and authenticated medical records. · Physician offices were contacted beginning 7-29-14 to arrange a time for record completion of accurate dates, times, authentication and their authors identified to for completion of a discharge summary for patients that stay over 48 hours and told they must complete records within 30 days of discharge. · Physician offices with incomplete medical records were contacted beginning 7-29-14 to arrange a time for record completion of discharge summaries/deaths, and authentication by the physician. · Records were brought by Health Information Management (HIM) staff to the units for physician completion. · Appointments were made with physicians directly and office managers for completion of incomplete medical records by 8-15-14. · Completion of incomplete files were done 8-15-14. · Unit clerks call HIM staff upon arrival of physicians to assist with completion of deficient medical records. **2. How are you going to prevent the deficiency from recurring in the future?**	

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	admitted 04/24/14 and discharged 05/16/14, lacked documentation of a discharge summary. 4. The medical record for patient N2, admitted 03/26/14 and discharged 04/23/14, lacked documentation of a discharge summary. 5. The medical record for patient N3, admitted 04/15/14 and expired 06/11/14, lacked documentation of a discharge/death summary. 6. The medical record for patient N5, admitted 01/28/14 and discharged 03/16/14, indicated a discharge summary dictated 05/09/14, but not authenticated by the physician. 7. The medical record for patient N7, admitted 05/09/14 and discharged 05/29/14, indicated a discharge summary dictated 05/29/14, but not authenticated by the physician. 8. The medical record for patient N8, admitted 04/26/14 and discharged 05/21/14, lacked documentation of a discharge summary. 9. The medical record for patient N9, admitted 05/20/14 and discharged 06/11/14, lacked documentation of a		· Physicians will be contacted within 24 hours of discharge of patients to dictate discharge summaries. · Beginning 8-11-14, letters will be sent to physicians 24 hours after discharge to include due date if discharge summaries are not done according to time frames noted in Medical staff Rules and Regulations guidelines. · Non compliant physicians will be discussed in the Medical Executive Committee Meeting (MEC) with recommendation for suspension. · Suspensions will be issued to non-compliant physicians by the CEO for records that are not completed within 30 days as noted in the Medical Staff Rules and Regulations. · HIM staff was assigned physicians on 8-8-14 to monitor twice/week to assure charts flagged for incompletion are completed. Within 30 days. · Beginning 7-29-14 incomplete records were also given to unit clerks for physician signatures/completion. · Administrative record closures will be conducted monthly to complete medical records with circumstances beyond our control i.e. physician death, refusal, no longer practices medicine. · Physicians with incomplete records will be reported in flash beginning 8-11-14.	

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	discharge summary. 10. The medical record for patient N10, admitted 01/03/14 and discharged 01/27/14, lacked documentation of a discharge summary. 11. The medical record for patient N11, admitted 03/11/14 and expired 03/13/14, indicated a discharge/death summary dictated 05/14/14, but not authenticated by the physician. 12. The medical record for patient N12, admitted 03/07/14 and discharged 03/28/14, indicated a discharge summary dictated 05/14/14, but not authenticated by the physician. 13. The medical record for patient N14, admitted 05/28/14 and discharged 06/11/14, lacked documentation of a discharge summary. 14. The medical record for patient N15, admitted 04/29/14 and expired 05/16/14, indicated a discharge/death summary dictated 05/16/14, but not authenticated by the physician. 15. The medical record for patient N18, admitted 04/23/14 and discharged 05/28/14, lacked documentation of a discharge summary.		· Incomplete records will be discussed at each HIM/MEC Committee meeting to include an action plan for compliance. · Beginning 8-11-14 random chart audits were done to assure 100% compliance is obtained. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The CEO. **1.By what date are you going to have the deficiency corrected?** · August 15, 2014	

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	16. The medical record for patient N19, admitted 03/04/14 and discharged 04/02/14, lacked documentation of a discharge summary. 17. At 11:15 AM on 07/17/14, staff member A4 confirmed the medical record findings.			
S001022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation, medical record review, policy and procedure review, and interview, the facility failed to ensure all medications were stored according to policy. Findings included: 1. During the tour of the 5th floor medication storage room at 10:10 AM on 07/16/14, accompanied by staff member A5, a bottle of Latanoprost eye drops was	S001022	**S1022** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · Beginning 7-18 staff was re-educated on the Medication Administration Policy in relation to storing refrigerated medications. · Beginning 7-18 staff was re-educated on the label on the medication that indicates which eye drops should be refrigerated.	08/08/2014

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	observed on an empty shelf above the individual patient medication bins. The eye drops were labeled for the patient in Room 5205 and a visible label indicated the drops should be kept refrigerated. 2. The medical record for the patient in Room 5205 indicated the Latanoprost eye drops were to be administered each bedtime and documentation indicated they were given the evening of 07/15/14. 3. The facility policy "Storage of Medications", last reviewed 02/2014, indicated, "6. Medications will be stored at appropriate temperatures. ...d. Temperature Monitoring: i. Pharmacy will oversee the continuous monitoring and maintenance of all drug storage refrigerators. ...18. Pharmacy will make a minimum of 2 rounds daily on patient care units." 4. At 11:40 AM on 07/16/14, staff member A12, pharmacist, indicated all items labeled for refrigeration should be kept refrigerated. 5. At 11:45 AM on 07/16/14, staff member A13, pharmacist, described the process of the pharmacy tech placing items in the medication refrigerator in the medication room in the nurses' station when they were ordered. After use, the		· Re-education of staff was initiated informing them that pharmacy will label medication with a warning to refrigerate after each use. · Beginning 7-28-14, minimum inspections of twice per day was done by pharmacy in areas where drugs are stored to assure appropriate temperatures are maintained. · Initiation of continuous monitoring and maintenance began 7-18-14 by pharmacy for all drugs stored in the refrigerator. · Initiation of rounding on patient care units was initiated 7-18 by pharmacy and will be done at least twice daily by pharmacy to assure appropriate temperatures and maintenance of all drugs stored in the refrigerator. · Rounding on patient care units was initiated on 7-18-14 by pharmacy to assure all items labeled for refrigeration are refrigerated. · Re-education of staff was initiated on 7-18-14 informing them that pharmacy will label medication with a warning if it must be refrigerated, medication requiring refrigeration will be placed in the refrigerator in the nurses station upon ordering, and after use medication that requires refrigerating must be returned to refrigerator after each use. · On 7-18-14 pharmacy was reminded when checking for outdated meds, discharged patients, and returned items to audit medications twice per day for	

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	nurse should return any items that require refrigeration to the medication refrigerator. He/she indicated the pharmacy tech made rounds twice daily to deliver medications and check for outdates, discharged patients, returned items, and should have noticed items left out that should have been refrigerated. 6. At 11:50 AM on 07/16/14, staff member A14, a nurse on the unit, indicated any eye drops that were labeled to be refrigerated should be kept in the refrigerator and returned there after each use. He/she indicated other eye drops were kept in a locked drawer in the individual patient's room. 7. At 9:00 AM on 07/17/14, staff member A20, pharmacy tech, indicated eye drops were normally stored in the refrigerator or in the individual patient bins in the storage room. He/she indicated if refrigerated ones were found during his/her rounds, he/she would return them to the medication refrigerator. He/she indicated he/she had already made rounds yesterday and must have missed the Latanoprost eye drops. 8. At 9:15 AM on 07/17/14, staff member A4 confirmed the discrepancies with the storage locations and the potential problem with refrigerated items		medication requiring refrigeration that may not be refrigerated. · Re-education of staff by the DQM was initiated on 7-18-14 informing them that medication requiring refrigeration must not be kept in a locked drawer in the individual patient's room; it must be refrigerated as indicated. · Re-education of staff by the educator was initiated on 7-25-14 informing them that medication requiring refrigeration must not be kept in a locked drawer in the individual patient's room; it must be refrigerated as indicated. · On 7-21-14 pharmacy initiated notifying nursing management when multi does medication requiring refrigeration is ordered. · Rounding on patient care units will be done at least twice daily by pharmacy to assure appropriate temperatures and maintenance of all drugs stored in the refrigerator. **2. How are you going to prevent the deficiency from recurring in the future?** · An audit tool was initiated by pharmacy 8-1-14, to check for refrigerated medication orders daily. · Pharmacy techs initiated daily audits of refrigerated medications on 8-1-14. · Monthly audits were initiated 8-1-14 by pharmacy to assure 100% of required refrigerated meds are refrigerated. · Random audits were initiated	

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	left out for prolonged times then returned to refrigeration.		8-1-14 by pharmacy to assure refrigerated items are not left out for prolonged periods then returned to the refrigerator. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The Director of Pharmacy. **1.By what date are you going to have the deficiency corrected?** · 8-8-14	
S001104	410 IAC 15-1.5-8 PHYSCIAL PLANT 410 IAC 15-1.5-8(a)(1)(A)(B) (a) The hospital shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the hospital license as follows: (1) The plant operations and maintenance service, equipment maintenance, and the environmental service shall be: (A) staffed to meet the scope of the services provided; and (B) under the direction of a person or persons qualified by education, training, or experience. Based on documentation review and staff interview, the Governing Board failed to ensure 4 of 4	S001104	**S 1104** **1. How are you going to correct the deficiency? If already corrected, included the steps taken**	08/15/2014

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	contracted Rehab Care staff members had fire safety training as per hospital policy (#6, 7, 8, and 9). Finding included: 1. Hospital Wide Education Plan policy #H-ML 11-001 (last reviewed 2/2012) indicated completion of required hospital-wide annual training includes Safety, Security, Emergency Preparedness, and Life Safety. 2. The training records of contracted staff (#6, 7, 8, and 9, Rehab Care) did not identify annual retraining of Emergency Preparedness as defined in Hospital Wide Education Plan policy. 3. At 9:45 AM on 7/16/2014, staff member #4, educator, confirmed the 4 contracted staff member (#6, 7, 8, and 9) from Rehab Care did not receive their hospital annual		**and the date of correction.** · Beginning 7-17 contracted rehab staff member files for (#6, 7, 8 and 9) were reviewed for hospital wide annual training including but not limited to Safety, Security, Emergency Preparedness and Life Safety. · Educators initiated completion of a hospital wide annual for contracted rehab staff members (#6, 7, 8 and 9) files including, /Fire Safety/Emergency Preparedness on 7-30-14. · Annual retraining will be done on contracted rehab staff members (#6, 7, 8 and 9) in July 2015. · A copy of completion of GHO/training records was placed in the contracted rehab staff employee staff files (#6, 7, 8 and 9) on 8-15-14. · Contracted rehab staff is required to complete annual hospital education/in-services which include fire safety prior to working on units and in the rehab gym. · Upon completion of GHO/training contracted rehab staff will be awarded a certificate of completion which will be placed in each contracted rehab staff members file. · Contracted rehab staff will train quarterly with the educator and host on Safety, Security, Emergency Preparedness and or Life Safety. **2. How are you going to prevent the deficiency from recurring in**	

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	training on Emergency Preparedness.		**the future?** · Education tracking will be recorded for contracted rehab staff in the Learning Management System (LMS) beginning 8-4-14. · Active contracted rehab staff and new hires will be reported monthly to the clinical educator by the Director of Rehab for completion of General Hospital Orientation (GHO)/training/re-training as part of the new hire requirements. · A "Clear to Work" sheet will be provided to the rehab contracted agency's director upon completion of GHO/training/re-training prior to working on the unit. · Yearly re-training will be done for contracted rehab staff with the educator, Hammond Fire Department, local agencies/organizations, and or the host related to emergency preparedness. · Random audits were initiated on 8-11-14 on contracted rehab care staff files to assure 100% compliance of completion of hospital wide annual training. **1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The Educator. **1.By what date are you going to have the deficiency corrected?** · 8-15-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/17/2014
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S001164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (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: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, observation, and staff interview, the facility failed to assure preventive maintenance was conducted on Physical Therapy training stairs and parallel bars. Findings included: 1. At 10:30 AM on 7/16/2014, the Rehabilitation Department was toured. The department contained parallel bars and training stairs. Neither piece of health care equipment had any preventive maintenance tag on them identifying the next scheduled preventive maintenance.	S001164	**S1164** - **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · The citation was sent Saturday, 7-26-14. The actual citation was received on Monday, 7-28-14. · The Materials Manager added the physical therapy training stairs and parallel bars to the healthcare equipment preventive maintenance (PM) list on 7-17-14. · Preventive maintenance was done 7-18-14 on the physical therapy training stairs and parallel bars. · The physical therapy training stairs and parallel bars was tagged with the next scheduled maintenance. · Preventive maintenance will be done annually in July on the physical therapy training stairs and parallel bars.	07/18/2014

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	2. The clinical engineering preventive maintenance records were reviewed with staff member #18, clinical engineering. The records did not identify either the parallel bars or training steps having a scheduled preventive maintenance program. 3. At 11:00 AM on 7/16/2014, staff member #16, nurse manager, indicated routine preventive maintenance on the Physical Therapy training stairs or the parallel bars had not been conducted.		**2. How are you going to prevent the deficiency from recurring in the future?** · The medical equipment management plan will be followed which includes a preventive maintenance process. · The medical equipment management plan preventive maintenance policy will be reviewed and or revised yearly. · The physical therapy training stairs and parallel bars were tagged with the current month, July 18, 2014, for preventive maintenance. · The physical therapy training stairs and parallel bars will be added to monthly Environment of Care (EOC) rounds to assure preventive maintenance is done and current. · Upcoming PM dates will be reported in the EOC committee bi-monthly to assure preventive maintenance compliance. · Random audits will be done to assure preventive maintenance is done on physical therapy training stairs and parallel bars, to assure 100% compliance. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · The Materials Manager. **4. By what date are you going to have the deficiency corrected?** · July 18, 2014	

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S001172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation, the hospital failed to ensure the two dialysis machines were clean while being stored in the Renal Dialysis Storage Room. Findings included: At 10:00 AM on 7/16/2014, the Renal Dialysis Storage Room was inspected in the presence of staff member #5, director of nursing. The room contained two dialysis	S001172	**S 1172** **1. How are you going to correct the deficiency? If already corrected, included the steps taken and the date of correction.** · On 7-18-14, the contracted dialysis company was contacted regarding infection control/cleanliness of their storage room and equipment. · On 7-18-14, the contracted dialysis company was asked to immediately clean their equipment and maintain infection control practices with equipment and staff. · On 7-18-14 dialysis equipment was cleaned by contracted staff.	07/25/2014

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	machines; both pieces of health care equipment were observed caked with dust and dirt debris on them.		**2. How are you going to prevent the deficiency from recurring in the future?** · On 7-24-14, the contracted dialysis company was added to the Contracted Services Tracking and Reporting Tool to assure cleanliness and infection control · The Contracted Services Tracking and Reporting Tool will be discussed monthly in the Patient Care and Safety/QM Committee Meetings. · Initiation of Infection control monitoring for contracted dialysis equipment began 7-18-14, and will also be monitored monthly in EOC rounding. · Random audits will be done to assure 100% compliance with cleanliness and infection control. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** · Infection Control/Employee Health Nurse. **1.By what date are you going to have the deficiency corrected?** · 7-25-14.	