

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2012
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S0000	<p>This visit was for investigation of two State hospital complaints.</p> <p>Complaint Numbers: IN 00111060 Substantiated with deficiencies cited related and unrelated to the allegations</p> <p>IN00116249 Unsubstantiated, lack of sufficient evidence: deficiencies cited unrelated to the allegations</p> <p>Date: 10/1/12 and 10/2/12</p> <p>Facility Number: 005043</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/27/12</p>	S0000		

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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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review, facility event report review, and staff interview, the nurse executive failed to ensure that nursing staff implemented the fall</p>	S0912	S01921. Deficiency has been corrected a. Fall Reduction Program policy # PTC 400 was reviewed and revised in draft format following the complaint investigation survey. Upon receipt	12/20/2012

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	<p>reduction program/policy for 5 of 6 patients (pts. #1, #2, #3, #11 and #12), failed to ensure the implementation of the pain policy for 2 of 2 patients who were on the 4 North Telemetry nursing unit (pts. #11 and #12), and failed to ensure that nursing staff implement physician orders for one patient in regards to an U/S (ultra sound) order to R/O (rule out) DVTs (deep vein thrombosis) for one patient (pt. #1).</p> <p>Findings:</p> <p>1. at 11:15 AM on 10/1/12, review of the policy and procedure "Fall Reduction Program", policy number PTC 400, with a last date revised of 3/2012, indicated:</p> <p>a. on page one under "I. Policy A. Inpatient Units:", it reads in "2. Reassessment": "a. Each patient will be re-evaluated every shift and as needed..."</p> <p>b. on page two under "III. Procedure", it reads: "The Morse Fall Risk Assessment for adults...will be completed on every bedded patient at time of admission, daily, following a fall, and when change in condition requires reassessment..."</p> <p>c. on page four under "VI. Interventions", in section "D. If a patient falls:", it reads: "1. Immediately assess the patient for injuries (abrasions, laceration, fracture, head injury). Assess for range of motion. Obtain vital signs...3. The RN (registered nurse) will</p>		<p>of the Notice of Non-Compliance Report on 12/5/12 the policy revisions were completed and implemented by 12/20/12. All clinical staff was notified of revisions to the Fall Reduction Program Policy on 12/20/12. b. Pain Assessment Policy was reviewed following survey and no revisions required. In October a weekly audit was conducted over 4 weeks to monitor patient records for documentation compliance with pain assessments. Results of the audit prompted development of a Pain Team which first met on 11/9/12. A Pain Assessment learning module was assigned to all acute care nursing staff. Pain Assessment Education was provided to clinical staff on 12/20/12. c. Ultrasound Call-in Guidelines Policy was reviewed and revised in draft format following the complaint investigation survey. Upon receipt of the Notice of Non-Compliance Report on 12/5/12 the policy revisions were completed and implemented on 12/19/12. Education was provided to all clinical staff by 12/20/12. The nurse involved in this case was coached by the department manager regarding ultrasound call-in guidelines for holidays. 2. To prevent the deficiency from recurring in the future: a. Will monitor documentation of Morse Fall Risk Assessment daily throughout admission by</p>				

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	<p>document the fall, notification of physician and family and any tests/treatments ordered in the medical record..."</p> <p>2. at 12:10 PM on 10/1/12, review of facility ERS (event reporting system) documents indicated one for pt. #1 was completed for a fall on 8/1/12 at 3:30 AM and noted in the area: "Family Notified" that the response by the nurse completing the form was: "No"</p> <p>3. review of patient medical records through out the survey process of 10/1/12 and 10/2/12 indicated:</p> <p>a. pt. #1 lacked any documentation by nursing staff on 9/3/12 at 3:30 AM, or later, that family was notified of the patient's fall</p> <p>4. interview with staff member #51, the nursing director for med/surg, telemetry and psych services, indicated:</p> <p>a. there was no documentation by nursing, in the medical record, of contact with the family/POA (power of attorney) for pt. #1 after the fall of 9/3/12</p> <p>b. the ERS document indicates family was not called after the fall for pt. #1 on 9/3/12 at 3:30 AM</p> <p>c. it is unknown why nursing did not notify family of the fall for pt. #1, except that it was the middle of the night,</p>		<p>conducting an audit of 20 patient records per month for 6 consecutive months. Will also monitor timely documentation of the Post Fall Assessment by conducting a 100% audit for any fall occurring on 4N for 6 consecutive months. Additionally, will also monitor documentation of family notification of a fall event by conducting a 100% audit for any fall occurring on 4N for 6 consecutive months. b. Will monitor documentation of pain reassessment of patients by conducting an audit of 20 patient records per month for 6 consecutive months. c. The Administrative Director of the involved department reviewed the ultrasound call-in guidelines with all staff members in a departmental communication posting in October 2012. 3. Individuals responsible for 1 and 2 above: a. CNO is responsible for compliance with Fall Reduction Program PTC400. b. CNO is responsible for compliance with Pain Assessment NUR630B. c. COO is responsible for compliance with Ultrasound Call-In Guidelines R-500. 4. Date of completion: 12/20/12</p>		

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	<p>however, the form was not completed until 7:14 AM and a call could have been made at that time</p> <p>5. review of patient medical records through out the survey process of 10/1/12 and 10/2/12 indicated:</p> <p>a. pt. #1 had documentation of a fall at 3:30 AM on 8/1/12 with the next Morse Fall Scale re-assessment done at 3:45 PM on 8/1/12</p> <p>b. pt. #2 had a fall noted at 11:45 AM on 9/2/12 with the next Morse Fall Scale re-assessment done at 2:30 PM on 9/2/12</p> <p>c. pt. #3 had a fall charted at 9:56 AM on 9/20/12 with the next Morse Fall Scale re-assessment done at 5:30 PM on 9/20/12</p> <p>d. pt. #11 was noted as having had a fall on 6/4/12 at 4:00 PM with the next Morse Fall Scale re-assessment done at 8:00 PM on 6/4/12</p> <p>e. pt. #12 was charted as having had a fall on 6/18/12 at 1:02 PM with the next Morse Fall Scale re-assessment done at 4:21 PM on 6/18/12</p> <p>6. interview at 2:00 PM on 10/1/12 and 4:40 PM on 10/2/12, with staff members #50, the chief nursing officer, and #51, indicated:</p> <p>a. the Fall Reduction policy has conflicting instructions to nursing staff as page one states patients will be</p>			

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	<p>re-assessed every shift for fall risk (see 1. a. above), and page two indicates the Morse Fall Risk Assessment will be done on admission and "daily" (see 1. b. above)</p> <p>b. per the Fall Reduction policy, nursing is to assess the patient immediately after a fall (see 1. c. above), but patients #1, #2, #3, #11 and #12 lacked documentation by nursing staff of any language that stated assessment for injuries was completed, range of motion was observed, and the Morse Fall Scale was performed immediately to be able to put safety interventions in place, if needed</p> <p>c. the Morse Fall assessment was done 12 hours and 15 minutes after the fall for pt. #1; 2.75 hours after the fall for pt. #2; &gt; 7.5 hours after the fall for pt. #3; 4 hours after the fall for pt. #11 and &gt; 3 hours after the fall for pt. #12</p> <p>d. the policy does not address what the meaning of "immediately" is for this facility</p> <p>e. nursing was documenting on the ERS forms that patients were assessed for injury, but were not documenting this in the patients' medical records</p> <p>7. at 11:15 AM on 10/2/12, review of the policy and procedure "Pain Assessment" with a policy number of NUR 630B, with a last date revised of 07/2012 indicated:</p> <p>a. under "Staff responsibilities in managing pain", in section "A...Response</p>			

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	<p>to pain intervention is assessed within 1 hour after pain intervention to determine effectiveness and to determine whether further intervention is needed..."</p> <p>8. review of patient medical records through out the survey process of 10/1/12 and 10/2/12 indicated:</p> <p>a. pt. #11 had pain documentation as follows:</p> <p>A. pain at 6/10 on 6/5/12 at 4:17 AM with "medication" given and follow up at 6:00 AM as "no pain" (&gt; 1 hour for follow up after medication given)</p> <p>B. at 5:09 AM on 6/7/12, pain was rated at 8 with medication given--the follow up re assessment was not until 7:15 AM with "no pain" documented (2 hours and 6 minutes after medication administration)</p> <p>C. on 6/8/12 at 12:45 AM, pain was an 8 with medication given--follow up was at 2:40 AM (&gt; 60 minutes after medication administration)</p> <p>D. at 4:36 AM on 6/8/12, pain was a 5 and the patient was medicated with pain rated "0" at 6:30 AM (&gt; 60 minutes after being medicated)</p> <p>b. pt. #12 had a pain level documented as "6" (out of 10) at 3:36 PM on 6/18/12 and was medicated with the follow up done at 5:07 PM (31 minutes late, per the facility pain assessment policy)</p>						

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	<p>9. interview with staff member #51 while reviewing patient medical records during the survey process of 10/1/12 and 10/2/12 indicated:</p> <p>a. nursing staff are not always following facility policy in following up with in 1 hour after medicating patients for pain</p> <p>10. at 11:45 AM on 10/1/12, review of the policy and procedure "Ultrasound Call-In Guidelines" with policy number R-500, with a most recent revised date of 04/11, indicated:</p> <p>a. under "Procedure", it reads: "...2. All Inpatient or ER (emergency room) requests after 11:00 pm Monday-Friday ordered STAT (now) for the following procedures ONLY:...Venous Doppler to R/O Deep Vein Thrombosis...3. Any physician ordering a procedure on an inpatient or an ER patient after 7:00 PM other than the above listed...will need to contact the Radiologist...personally...4. On Weekends and holidays, any Inpatient requests received on Saturday until 7:00 pm. Otherwise the STAT PROCEDURE LIST applies..."</p> <p>11. review of patient medical records through out the survey process of 10/1/12 and 10/2/12 indicated:</p> <p>a. pt. # 11 had a physician order written on Monday (of Memorial Day weekend)</p>			

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	<p>at, or about, 10:36 AM on 5/28/12 that reads: "Venous U/S L lower extremity R/O DVT--U/S Imaging of L groin seroma/...(?hematoma)...extent"</p> <p>b. pt. #11 had a later telephone order written by nursing at 6:30 PM that read: "O.K. to do US venous LLE (left lower extremity) 5/29/12 a.m."</p> <p>12. At 11:45 AM on 10/1/12 and 4:40 PM on 10/2/12, interview with staff member #53, Director of Radiology, indicated:</p> <p>A. ultra sound techs are available on call after routine hours (routine hours = 7 AM to 11 PM Monday through Friday)</p> <p>B. there are 5 procedures on the "Call-In Guidelines" for ultra sound staff that are "life threatening" and they should be done any time ordered, even weekends and holidays</p> <p>C. during weekends and holidays, if an "any ultra sound is ordered" prior to 7 PM, "even a big toe", ultra sound techs/staff should be called in</p> <p>D. after 7 PM, if the ultra sound was not for one of the 5 procedures listed as serious/life threatening, a physician would be required to make "physician to physician" contact with the Radiologist to explain the need for an ultra sound after hours instead of the next business day</p> <p>E. an ultra sound ordered at 10:36 AM on 5/28/12 (Memorial Day) for a Venous</p>			

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	<p>U/S L lower extremity R/O DVT U/S imaging of L groin seroma/.../extent" should have had the ultra sound tech called in to perform the test</p> <p>13. interview with staff member #50 at 4:40 PM on 10/2/12 indicated:</p> <p>a. the "Ultrasound Call-In Guidelines" are confusing as to when technicians are to be called in</p> <p>b. it is unclear why nursing staff waited between 10:36 AM and 6:30 PM to call the physician and get the order changed to do the ultrasound on 5/29/12</p>			