STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151331	A. BUILDING 00 B. WING	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON COUNTY HOSPITAL	1141 HOSPITAL DR NW CORYDON, IN 47112

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S 0000 Bldg. 00	This visit was for the investigation of a State Licensure Hospital complaint. Complaint Number: IN00445690- Deficiency related to the allegation is cited. (Tag 930) Survey Date: 1/13/25 Facility Number: 004773 QA: 1/23/2025	S 0000		
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, Nursing Services failed to perform vital signs every hour per policy for 1 of 5 MRs (Medical Records) reviewed; and failed to assign correct priority/triage level/classification for 3 of 5 MRs reviewed. (P2, P3, P4) Findings include: 1. Facility policy titled Initial Patient Assessment/Triage, no policy number, Date Reviewed Revised: 11/1/24, Under Policy/Procedure: To provide guidelines to all personnel working in the Emergency Department	S 0930	a ESI Level education provided to all emergency department nurses via email. Attachment A. b Patient Care and Evaluation - Initial Patient Assessment/Triage policy and procedure updated to reflect ESI Level 3 changes of: N/V/D with stable VS per ESI guidelines. Attachment C.	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Lieber	COO	02/13/2025

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	for timely and accurate gathering of patient information and the triage process. Under Procedure, 3. An RN (Registered Nurse) must assign the patient priority/triage level/classification to determine the "order" in which patients will be seen. Using the Emergency Severity Index (ESI), patients will be prioritized based on the urgency of the condition, as well as what resources will be needed to get through to an ED disposition. Possible resources include: Labs, X-ray, IV (Intravenous) fluid for hydration. Priority Levels: Level 3: Urgent/Two or more resources: requires in-depth evaluation, and at least 2 resources. VS (Vital Signs) are within normal parameters for patient age. Level 4: Less Urgent/One resource: requires a physical exam and one resource. Stable. 6. Patients who have already been triaged, and are waiting to be taken to an ED room, will be reassessed: A. For levels 1-3 triage acuity: every 1 hour, or at the discretion of the RN. 7. Patients that have been placed in an ED room will be reassessed along with a full set of vital signs obtained every hour unless their condition warrants a more frequent assessment. 2. Review of P2 MR indicated: a. P2 presented to the ED on 10/20/24 at 1711 hours with complaints of low blood sugar of 44 at home. b. Nursing Assessment note indicated P2 Triaged at level 4-less Urgent, BP (Blood Pressure) 160/105, Heart Rate 85, Respirations 17, SpO2 (peripheral capillary oxygen saturation 97%. Blood sugar reading during Triage 115. Reference Range for Systolic Blood Presssure [90-120], Diastolic Blood Pressure [60-80], Peripheral Pulse Rate [60-100]. c. Emergency Documentation Provider note indicated Associated Diagnoses: Hypoglycemia; Screening general; Vomiting. History of Present		c Patient Care and Evaluation - Initial Patient Assessment/Triage policy and procedure, specifically "Patients who remain in waiting room" and "Patients wo are placed in the ED room or hallway bed" sections and updated changes to ESI Level 3 were reviewed with all emergency department nurses via email to ensure compliance with the policy. Attachment A. d Specific education regarding patient reassessment with a full set of vital signs was conducted via email for all emergency department. Attachment A. e PI monitor updated to reflect vital sign documentation. Attachment D. f Added to the current PI Monitor the accuracy of selecting ESI levels. Attachment D. **Prevention:**	

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	Illness: Patient brought by friends to ED with complaints of low blood sugar and low oxygen. Patient had single episode of vomiting, denies past medical history. No dizziness, lightheadedness. Physical Examination: listed Heart Rate 89, Respirations 16, SpO2 96% on Room Air. BP not listed. Medical Decision Making: Differential Diagnosis: Nausea, vomiting, abdominal pain, gastroenteritis. Rationale: Glucose and oxygen appropriate throughout ED course. Patient did not have continued vomiting. Denies issues with diarrhea. Patient alert and oriented, excessively giggly throughout ED course. Documents reviewed: ED nurse's notes. Reexamination/Reevaluation: Heart Rate 96, Respirations 14, BP 148/94, SpO2 99%. Plan: Condition: Stable, Disposition: Medically cleared, discharged to home. d. P2 discharged to home in stable condition on 10/20/24 at 1759 hours with educational material regarding nausea and vomiting, prescription for Ondansetron for nausea and vomiting, and instructions to follow up with PCP (Primary Care Provider) in 5 to 7 days. e. P2 triaged at level 4 with Blood Pressure reading outside normal parameters for patient age. f. MR lacked documentation of resources ordered to determine cause of elevated Blood Pressure. 3. Review of P3 MR indicated: a. Patient presented to the ED on 10/20/24 at 1309 hours with complaints of Hyperglycemia since 10/18/24. b. Nursing Assessment note indicated P3 Triaged at level 3 Urgent/Two or more resources. BP 147/124, Heart Rate 110, SpO2 96%. Reference Range for Systolic Blood Presssure [90-120], Diastolic Blood Pressure [60-80], Peripheral Pulse Rate [60-100]. c. Emergency Documentation Provider Note		a PI Monitor to ensure compliance with every 1 hour vital sign documentation. Attachment D b PI Monitor to ensure compliance with ESI Levels. Attachment D **Responsible Party:** Emergency Department Manager **Completion Date:** February 14, 2025	

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	indicated Associated Diagnosis: Type 2 Diabetes mellitus with hyperglycemia. History of Present Illness: P3 presented to ED in private vehicle, known diabetic with previous Hemoglobin A1C (Glycated hemoglobin) 8. Patient unable to decrease A1C with diet and exercise. Patient has been off Diabetic medication for 6 months, checked blood sugar at home with reading greater than 500, phoned PCP and was instructed to go to ED. Patient denies fever, chills, chest pain, Shortness of Breath, abdominal pain, nausea, vomiting and diarrhea. Physical Examination: Heart Rate 110, BP 147/124, SpO2 96%. Medical Decision Making: EKG (Electrocardiogram): Sinus Rhythm, Rate of 91, Left axis deviation. Chest X-ray normal. Reexamination/Reevaluation: No vital signs recorded. Course: Progressing as expected. Assessment: exam improved. Plan, Condition: Improved, Stable. Disposition: Medically Cleared. d. Patient discharged to home on 10/20/24 at 1505 hours with education on Glucose Monitoring, Diabetes, and follow up with PCP in 5-7 days. Metformin sent to the pharmacy. e. MR lacked documentation of reassessment every hour with vital signs every hour as indicated for Triage levels 1-3. f. MR indicated incorrect Triage Level 3 for P3 with BP 147/124 and Heart Rate 110, not within normal parameters for patient as indicated for Level 3. 4. Review of P4 MR indicated: a. Patient presented to the ED on 7/24/2024 at 1028 hours with complaints of elevated blood pressure. b. Nursing Assessment note indicated P4 Triaged at Level 3 Urgent/Two or more resources. BP 203/126, Heart Rate 88, Respiratory Rate 18, SpO2 100%. Reference Range for Systolic Blood Presssure [90-120], Diastolic Blood Pressure			

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	[60-80], Peripheral Pulse Rate [60-100]. Chief Complaint: P4 presented to ED with complaints of high blood pressure. Patient took Lisinopril 20 mg (milligrams) and went outside to work. When patient came back inside blood pressure was 190's/120's. Patient denies symptoms. c. Emergency Documentation Provider Note indicated Associated Diagnosis: Hypertension. History of Present Illness: Patient presented to ED with high blood pressure. Current degree of blood pressure 183/102, no symptoms, denies chest pain, Shortness of Breath, headache and weakness. The maximum degree of hypertension 203/126. Patient took Lisinopril 20 mg prior to ED visit. Physical Exam at 1050 hours BP 203/126, at 1130 hours BP 169/92, at 1200 hours BP 160/84. Medical Decision Making: Differential Diagnosis: Uncontrolled Hypertension, asymptomatic, hypertension, non-compliance. Rationale: P4 presented to ED with elevated blood pressure that got worse after taking medication. Patient did admit to going to Amusement Park the day before and not following any sort of diet with possible increased sodium intake. P4's labs and urine essentially normal. EKG and Chest X-ray normal. Blood pressure decreased since arrival and patient asymptomatic since arrival to ED. Follow-up previously scheduled with PCP and instructed patient to return to ED for worsening symptoms. d. Patient discharged to home on 7/24/24 at 1212 hours with Condition improved, education on Hypertension, limiting sodium intake and increasing water intake. Follow up with PCP in 5-7 days. e. MR indicated incorrect Triage Level 3 for P4 with BP 203/126, not within normal parameters for patient as indicated for Level 3. 5. In interview on 1/13/25 at approximately 1130 hours with A2 (ED Nursing Manager), he/she			

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	confirmed P3 and P4 should have been triaged at level 2 instead of level 3 due to vital signs outside of normal parameters for patient. A2 also confirmed P3's MR lacked documentation of vital signs performed every hour per policy after patient placed in an ED room, and P2 Triaged incorrectly at level 4 with Blood Pressure reading outside normal parameters for patient's age.			