

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
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NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN47747
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S0000	<p>This visit was for the investigation of one (1) State hospital complaint.</p> <p>Complaint number: IN00094421 Substantiated; deficiency related to allegations is cited.</p> <p>Date of survey: 11-21-11</p> <p>Facility number: 005074</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: clauglin 01/06/12</p>	S0000		
S0930	<p>410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and staff interview, the nursing staff failed to follow facility policy related to meal consumption for 4 of 5 patients (patients</p>	S0930	CORRECTIVE ACTION PLAN for Complaint No. IN00094421 Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:	12/21/2011

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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	<p>#1, 2, 4, and 5) and failed to notify dietary or the physician of poor intake for 2 of 5 patients (patients #1 and 5).</p> <p>Findings include:</p> <p>1. Facility policy provided by the director of nursing from Mosby last reviewed/revised 4/10 and 1/11 with no changes made on 1/11 states the following: (A) Page 2 states under patient and family education, second paragraph: ".....If intake falls below 75% for any length of time, refer the patient to a registered dietitian for medical nutrition therapy." (B) Page 5 states under "MONITORING AND CARE": 2. Weigh patient daily (if nutrition has been inadequate) and recommend calorie count." (C) Page 6 states under "DOCUMENTATION": "Patient's tolerance of diet and amount eaten."</p> <p>2. Review of patient #1 medical record indicated the following: (A) He/she was admitted from a longterm care (LTC) facility on 7/24/11 after a fall resulting in a fractured hip. (B) The meal consumption documentation was not complete. There were several missing entries. There was no documentation of meal intake for</p>		<p>Responsible Parties: Target Date: Status effective Date of Submission of POC: S 930 Revise Mosby's Skills Nursing P&P "Oral Nutrition Assistance for Adult Patients", addressing nursing care and documentation requirements for patients with compromised dietary consumption and need of dietitian referral and physician notification as needed. Education will be provided for all Inpatient RNs and PCAs regarding assessment, reassessment, intervention, evaluation and prevention of inadequate nutritional intake in patients. Review of P&Ps and documentation requirements for the completion of interventions including dietary intake, physician notification, and dietician referral process will be via Web Inservice (computer based training) and will reference Mosby's "Oral Nutrition Assistance for Adult Patients" and Policy and Procedure No. 40-29 "Patient Assessment/Reassessment", Nursing Managers, Registered Dieticians Employee Education and Development, Registered Dieticians, Nursing Managers of IP Units P&P revisions completed by January 31, 2012. Policy approvals February 14, 2012.P&Ps effective February 15, 2012. Establish educational content and create Web In-service by January 31, 2012. In Progress: Discussions began</p>		

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	<p>lunch on 7/25/11, no documentation of breakfast or lunch on 7/26/11, no documentation of lunch on 7/27/11, no documentation of breakfast or lunch on 7/28/11 and no documentation of breakfast on 7/29/11. The documentation that was charted indicated the patient had a very poor intake. The notes indicated that on 7/25/11 at 1729 the patient ate 1%, on 7/26 the only meal documentation was at 10:02 p.m. and it was documented as 10%, on 7/27/11 meal consumption was documented as 10% at 7:54 a.m. and 5% at 9:54 p.m., on 7/28/11 the only documentation was at 7:27 p.m. of an intake of 15%.</p> <p>(C) The patient's fluid intake was also poor. He/she had a po (by mouth) intake of 220 cc on 7/25/11, 490 cc on 7/26/11, 300 cc on 7/27/11 and 710 cc on 7/28/11.</p> <p>(D) The patient was not placed on daily weights. Documentation indicated the patient was weighed on 7/24/11 and 7/25/11 only.</p> <p>(E) The record indicated that the physician was not notified of the poor dietary intake until 7/28/11 after the family voiced concerns due to poor dietary intake and requested intervention.</p> <p>(F) Dietary was not notified of the poor intake and need for interventions.</p> <p>3. Review of patient #2 medical record indicated the following:</p>		<p>January 12, 2012. In Progress In Progress Web Inservice development in progress. Discussions began 01/16/12. Web in-services to be completed by 75% of assigned employees by February 29, 2012, and 100% of assigned employees by March 29, 2012.</p> <p>S 930 Adherence to P&P nutritional documentation requirements. EMR Documentation audits on OMCC and GW Ortho units (a minimum of 30 records/month): · % of meal eaten · Appropriate dietician referral and, if needed, physician notification, for nutritionally compromised patients · Documentation of daily weights, as ordered Appropriate Corrective action will be taken for employees who do not follow the policies. OMCC and GW Ortho Managers and Registered Dieticians Audit tool to be developed by January 23, 2012. Baseline audits to be conducted in February, 2012 and monthly thereafter until compliance rate of 90% is reached. Audit tool development completed January 23, 2012.</p>		

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	<p>(A) He/she was admitted 7/26/11 for a total knee arthroplasty.</p> <p>(B) A problem was identified with meal consumption documentation. There was no documentation of meal intake for lunch or supper on 7/27/11, no documentation of breakfast on 7/28/11, and no documentation of any meal on 7/29/11.</p> <p>4. Review of patient #4 medical record indicated the following: (A) He/she was admitted on 7/29/11 for surgery after a fractured leg. (B) A problem was identified with meal consumption documentation. He/she had no meal consumption documented on 7/30/11 and only one entry on 7/31/11 at 1808.</p> <p>5. Review of patient #5 medical record indicated the following: (A) He/she was admitted on 7/23/11 due to hip pain with possible infection and a urinary tract infection. (B) A problem was identified with meal consumption documentation. The medical record lacked documentation of any meal consumption for 7/23/11-7/27/11. (C) The patient did not have a daily weight. He/she had no weight documented for 7/27/11, 7/28/11 or 7/29/11.</p>				

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	(D) The record lacked documentation that the physician was notified of the patients poor meal consumption 7/23/11-7/27/11 or that dietary was notified of poor meal consumption and need for intervention. 6. Staff member #5 verified the medical record documentation beginning at 3:30 p.m.				