

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2013
NAME OF PROVIDER OR SUPPLIER  SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
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S000000	<p>This visit was for one (1) State complaint investigation.</p> <p>Dates of survey: 02/26/13</p> <p>Facility number: 004975</p> <p>Complaint number: IN00122716 Substantiated; deficiencies cited related and unrelated to allegations</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/18/13</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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S000926	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(1)</p> <p>(b) The nursing service shall have the following:</p> <p>(1) Adequate numbers of licensed registered nurses, licensed practical nurses, and other ancillary personnel necessary for the provision of appropriate care to all patients, as needed, to include the immediate availability of a registered nurse.</p> <p>Based on document review and staff interview, the facility failed to ensure adequate staff was provided on the Behavioral Health Services (BHS) unit for 17 of 22 days reviewed and on the day of survey.</p> <p>Findings include:</p> <p>1. Staffing was reviewed for 1/1/13 through 1/22/13 and the following was identified:</p> <p>(A) The unit was staffed with only two (2) nursing assistants on nightshift on 1/1/13 for a census of fifteen (15) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(B) The unit was staffed with only two (2) nursing assistants on dayshift on 1/2/13 for a census of fourteen (14) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(C) The unit had no nursing assistants</p>	S000926	<p><b>Who is responsible:</b></p> <p>Nursing Director/Schedule coordinator Brandy Greene, RN will be utilizing a nursing staffing agency contracted by Ginger Ottersbach, RN, CNO with the approval of Merlyn Knapp, CEO. Brandy Greene and Ginger Ottersbach will also ensure that all employees sent from this nursing staffing agency will complete required orientation training. Ginger Ottersbach, RN will also be hiring additional permanent nursing staff and Brandy Greene, RN will ensure hospital orientation is completed before placing this additional staff on the nursing schedule.</p> <p><b>What is the plan of correction:</b></p> <p>A nursing staffing agency with fully hospital oriented staff will be utilized to help fulfill staffing needs due to fluctuations in census and/or shortages due to</p>	02/27/2013	

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	<p>working on nightshift on 1/1/13 for a census of fourteen (14) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(D) The unit was staffed with only two (2) nursing assistants on nightshift on 1/4/13 for a census of fifteen (15) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(E) The unit was staffed with only two (2) nursing assistants on nightshift on 1/5/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(F) The unit was staffed with only two (2) nursing assistants on nightshift on 1/6/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(G) The unit was staffed with only 1.5 nurses on dayshift on 1/7/13 for a census of sixteen (16) patients and the staffing guidelines called for two (2) licensed staff.</p> <p>(H) The unit was staffed with only 1.5 nurses on dayshift on 1/10/13 for a census of seventeen (17) patients and the staffing guidelines called for two (2) licensed staff.</p> <p>(I) The unit was staffed with only two (2) nursing assistants on nightshift on 1/10/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants.</p>		<p>staff illness/call-ins.</p> <p>Additional permanent nursing staff will be hired and will be added to the nursing schedule after completing hospital orientation.</p> <p><b>When the plan of correction will begin:</b></p> <p>The contract with the nursing staffing agency was entered into on 1/17/2013 with this staff orientation and utilization occurring by 2/27/2013. Additional permanent hospital staff hiring, orientation and utilization began on 2/27/2013 and is on going as staffing needs arise.</p> <p><b>How the plan of correction will occur:</b></p> <p>Fully oriented nursing staff from the contracted staffing agency and fully oriented newly hired permanent nursing staff will be utilized on the nursing schedule to ensure staffing guidelines are followed and adequate nursing staff present according to patient census and these staffing guidelines. This staff will also be available for staffing shortages due to an increase in hospital census and staff illness related call-ins.</p>		

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	(J) The unit was staffed with only 1.5 nurses on dayshift on 1/12/13 for a census of sixteen (16) patients and the staffing guidelines called for two (2) licensed staff. (K) The unit was staffed with only two (2) nursing assistants on nightshift on 1/12/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants. (L) The unit was staffed with only two (2) nursing assistants on nightshift on 1/13/13 for a census of seventeen (17) patients and the staffing guidelines called for three (3) nursing assistants. (M) The unit was staffed with only two (2) nursing assistants on nightshift on 1/14/13 for a census of seventeen (17) patients and the staffing guidelines called for three (3) nursing assistants. (N) The unit was staffed with only two (2) nursing assistants on nightshift on 1/15/13 for a census of eighteen (18) patients and the staffing guidelines called for three (3) nursing assistants. (O) The unit was staffed with only one (1) nursing assistants on nightshift on 1/16/13 for a census of seventeen (17) patients and the staffing guidelines called for three (3) nursing assistants. (P) The unit was staffed with only one (1) RN on dayshift on 1/17/13 for a census of seventeen (17) patients and the staffing guidelines called for two (2)						

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	<p>licensed staff.</p> <p>(Q) The unit was staffed with only one (1) RN on nightshift on 1/17/13 for a census of seventeen (17) patients and the staffing guidelines called for two (2) licensed staff.</p> <p>(R) The unit was staffed with only two (2) nursing assistants on nightshift on 1/18/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(S) The unit was staffed with only two (2) nursing assistants on nightshift on 1/20/13 for a census of seventeen (17) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(T) The unit was staffed with only two (2) nursing assistants on dayshift on 1/21/13 for a census of seventeen (17) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>(U) The unit was staffed with only two (2) nursing assistants on dayshift and nightshift on 1/22/13 for a census of sixteen (16) patients and the staffing guidelines called for three (3) nursing assistants.</p> <p>2. On the day of survey, the BHS unit had a census of twenty one (21) patients and was staffed with two (2) RNs. The unit staffing guidelines call for three (3) licensed staff for a census of 21 patients.</p>			

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	3. Staff member #1 indicated in interview at 3:00 p.m. on 2/26/13 that the staffing information was correct and the BHS unit was short staffed as indicated above.				

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S000930	<p>410 IAC 15-1.5-6 NURSING SERVICE 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, observation, and staff interview, the registered nurse failed to assure meals were documented for 4 of 5 patients (patients #1, #2, #4, #5), failed to assure 4 of 5 patients (patients #2, #3, #4, #5) were weighed as ordered and failed to assure vital signs were completed as ordered for 2 of 5 patients (patients #1, #2) on the Behavioral Health Services (BHS).</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record indicated the following: (A) Facility document titled " GRAPHIC RECORD " lacked documentation that the patient received a meal tray during his/her stay at the facility. The section had a dash (---) through each box where meal consumption would be recorded. The patient was discharged in the early evening of 1/4/13 and should have received three (3) meals during his/her stay. (B) An order was written on 1/3/13 to</p>	S000930	<p><b>Who is responsible:</b></p> <p>Ginger Ottersbach, RN, CNO, Brandy Greene, RN (Nursing Director), and Krista Hall, RN (EMR coordinator), Chrissy Perra, RN (PM House Supervisor)</p> <p><b>What is the plan of correction:</b></p> <p>Installation of a new computer system and EMR with staff training by support persons from the company of purchase, as well as hospital EMR coordinator, began in March of 2013 with go live date of 04/01/2013. This system includes daily documentation requirements for each patient including but not limited to ordered vital signs, weights, meal consumption and intake and output. These documentation requirements have been flagged in the system in such a way that the documenting nurse or CNA cannot proceed until these fields are documented.</p> <p>Monthly nursing staff meetings will be held to ensure all nursing</p>	03/01/2013	

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	<p>obtain the patients vitals signs twice daily. There were no vital signs obtained on 1/4/13. He/she was discharged at 4:00 p.m. on 1/4/13.</p> <p>2. Review of patient #2 medical record indicated the following: (A) An order was written on 1/4/13 to weigh the patient weekly and obtain vital signs twice daily. There was no weight documented in the record. Document titled " GRAPHIC RECORD " had a section for weight to be listed, however the document stated " scale broke " . There were no vital signs obtained on 1/11/13. The section was left blank. (B) Facility document titled " GRAPHIC RECORD " lacked documentation that the patient received a meal tray for breakfast and lunch on 1/11/13. The section on the document was left blank. Additionally, the patient had no a.m. vital signs taken on the day of discharge (1/11/13).</p> <p>3. Review of patient #3 medical record indicated the following: (A) An order was written on 1/4/13 to weigh the patient weekly. The medical record lacked documentation that a weight was obtained during the hospital stay. The section to document the weight stated "scale broke". The patient was discharged on 1/15/13.</p>		<p>staff are following EMR documentation guidelines, provide EMR use updates, and allow for question and answer session. These staff meetings will also be utilized to re-educate staff on any documentation issues noted in chart audits. These chart audits will be completed on a daily basis beginning 03/01/2013 and continue for the first two months following EMR go live.</p> <p><b>When the plan of correction will begin:</b></p> <p>03/01/2013</p> <p><b>How the plan of correction will occur:</b></p> <p>Daily chart audits to ensure documentation of vital signs, weights, meal consumption, and intake and output will be done for 3 consecutive months. Go live of EMR system which will flag these documentation requirements in such a way the nurse or CNA will not be allowed to proceed until these fields are documented. Monthly nursing staff meetings will be held to ensure all nursing staff are following EMR documentation guidelines, provide EMR use updates, and allow for question and answer session. These staff meetings will also be utilized to re-educate staff on any documentation issues noted in chart audits.</p>				

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	<p>4. Review of patient #4 medical record indicated the following:</p> <p>(A) An order was written on 1/4/13 to weigh the patient weekly. The medical record lacked documentation that the patient was weighed during the hospital stay. The " GRAPHIC RECORD " stated " scale broke " .</p> <p>(B) It could not be determined that the patient received dinner on 1/21/13 or breakfast on 1/22/13. The medical record lacked documentation of meal consumption for each. The section on the "GRAPHIC RECORD" was left blank. The patient was discharged on 1/22/13.</p> <p>5. Review of patient #5 medical record indicated the following:</p> <p>(A) An order was written on 1/5/13 to weigh the patient weekly and check vital signs twice daily.</p> <p>(B) The patient was not weighed during his/her stay. The " GRAPHIC RECORD " stated " scale broke " in the section where weights would be documented. The patient was at the facility until 1/22/13.</p> <p>(C) It could not be determined that the patient received a meal for breakfast and lunch on the day of discharge. The meal consumption documentation was left blank.</p>				

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	<p>6. Per observation at 1:00 p.m. on 2/26/13, the scales were in working order.</p> <p>7. Staff member #4 verified the medical record documentation as above beginning at 1:58 p.m. on 2/26/13.</p> <p>8. Facility policy titled "BHS Unit Specific Policy and Procedure: Intake and Output Monitoring" (no revision date listed) states under procedure "....2. Nursing assistants and mental health techs will record all meal consumption and bowel movements on the "NA Assignment/Report Sheet".....This sheet will then be turned into the appropriate nurses, based on shift and patient assignment. 3. The nurse assigned to the patient is responsible for recording meal consumption, and intake and output in the medical record, on the graphics sheet....."</p>			

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S000946	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.</p> <p>Based on document review and staff interview, the facility failed to ensure medications were administered according to physician orders for 3 of 5 patients (patients #1, #3, #5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of patient #1 medical record indicated the following:           <p>(A) Review of the medication administration record (MAR) indicated the patient received Miralax, Aspirin, Meclizine, Clonidine, Lisinopril, Hydrochlorothiazide, and Lopressor without an order.</p> </li> <li>Review of patient #3 medical record indicated the following:           <p>(A) An order was written on 1/8/13 at 5:15 a.m. for Clonidine .1 mg every 6</p> </li> </ol>	S000946	<p><b>Who is responsible:</b></p> <p>Ginger Ottersbach, RN, CNO, Brandy Greene, RN (Nursing Director), Krista Hall, RN (EMR Coordinator)</p> <p><b>What is the plan of correction:</b></p> <p>Computerized physician order entry go live date of 5/20/2013 as second phase of EMR implementation with all nursing staff education completed the week prior to go live date. System of order entry includes a process of two medication order verifications after orders are entered by the physician. Nurse and pharmacy will verify new medication orders.</p> <p>Nursing staff re-education by read and sign inservice regarding policies for medication administration and medication</p>	05/20/2013

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	<p>hours prn if systolic blood pressure (SBP) is 150-179, Clonidine .2 mg every 6 hours prn if SBP is 180-199, and Clonidine .3 mg every 6 hours if SBP is &gt; 200.</p> <p>(B) The patient's SPB was 177 at 8:00 a.m. on 1/8/13, 156 at 8:00 a.m. on 1/14/13, 177 at 8:00 p.m. on 1/14/13, and 186 at 8:00 a.m. on 1/15/13. No prn Clonidine was administered for the increased blood pressures.</p> <p>3. Review of patient #5 medical record indicated the following: (A) An order was written at 5:15 a.m. on 1/16/13 for Clonidine .1 mg every 6 hours prn for SBP &gt; 150. (B) Review of the vital signs on facility document titled " GRAPHIC RECORD " indicated the patient's systolic blood pressure was 174 at 8:00 a.m. on 1/16/13, 188 at 8:00 a.m. on 1/20/13, 177 at 8:00 p.m. on 1/20/13 and the Clonidine was not administered for the increased blood pressures.</p> <p>4. Staff member #4 verified the medical record documentation as indicated above beginning at 1:58 p.m. on 2/26/13.</p>		<p>orders to ensure all staff vigilance in taking, receiving, entering, and implementation of medication orders.</p> <p><b>When the plan of correction will begin:</b></p> <p>05/20/2013</p> <p><b>How the plan of correction will occur:</b></p> <p>The week prior to computerized physician order entry go live date all nursing staff, physicians, and pharmacy staff will receive training from Krista Hall, RN (EMR Coordinator) under the instruction of staff from the company in which this system was purchased. This training will include the process of order entry in this system in which two medication order verifications are completed after orders are entered by the physician. Nursing staff and Pharmacy staff will receive training on double verification of new medication orders.</p> <p>A read and sign in-service written by Brandy Green, RN and approved by Ginger Ottersbach, RN, CNO, will also be presented this week of computerized order entry training for nursing and pharmacy staff. This in-service will re-educate nursing and pharmacy staff regarding policies for medication administration and</p>		

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			medication orders to ensure all staff vigilance in taking, receiving, entering, and implementation of medication orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2013
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S001318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW &amp; DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on document review and staff interview, the facility failed to transfer patients with appropriate records per the patients request for 1 of 5 patients (patient #1).</p> <p>Findings include;</p> <p>1. Review of patient #1 medical record indicated the following: (A) The patient presented to the emergency department (ED) at 4:00 p.m. on 1/3/13 with chief complaint listed as</p>	S001318	<p><b>Who is responsible:</b> Michelle Waldrip (Social Worker), under the direction and supervision of Brandy Greene, RN (Nursing Director), and Ginger Ottersbach, RN, CNO <b>What is the plan of correction:</b> The implementation of a system to document and track all discharge teaching instructions, which includes computerized documentation that encompasses all of the patient care issues addressed for that patient stay. <b>When the plan of correction will begin:</b> 02/27/2013 <b>How the plan of</b></p>	02/27/2013	

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	<p>behavioral disturbance/dementia.</p> <p>(B) He/she was admitted to the BHS.</p> <p>(C) The psychiatric assessment indicated the patient was admitted for medication stabilization. Under assessment and plan, the document states " Adjust medications. Individual and group therapy session. Behavioral therapy ... .. "</p> <p>(D) The initial treatment plan was initiated on 1/3/13 and listed problems of: suicidal, hallucination, active medical concerns and fall risk.</p> <p>(E) Nurses notes at 1:00 p.m. on 1/4/13 states " Pt states he wants to transfer to (facility #2). Nurse manager informed. Family present. (M.D. #1) D/C pt to family. "</p> <p>(F) The discharge summary states on page 2: " Patient stated that (he/she) wanted to be transferred to (facility #2). Family was present at the time of the request and patient was discharged to the family. "</p> <p>(G) The discharge instruction sheet listed medications to be taken only. The document did not have any follow-up care listed nor specific instructions to deal with patients issues listed on the admission documents.</p> <p>(H) The medical record lacked evidence that the facility contacted facility #2 and arranged transfer of patient #1 per the patients request for transfer there. The</p>		<p><b>correction will occur:</b> The facility has employed a full time social worker, Michelle Waldrip, to plan, oversee and assist with all discharge planning needs for patient's and their family. This Social Worker began employment on 2/11/2013. Nursing notes, as well as social worker notes, are documented in a computerized charting system which prompts the narrator to provide discharge information. Discharge documentation education has been provided to staff who participate in discharge reporting.</p>		

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	<p>patient was discharged to his/her family at 4:00 p.m. on 1/4/13.</p> <p>2. Staff member #1 indicated the following in interview beginning at 11:40 a.m. on 2/26/13: (A) The grandchild of patient #1 visited and demanded the patient be transferred to facility #2 because he did not want the patient at facility. (B) The facility was not going to waste their time arranging for the patient to go to facility #2 just because he/she did not want the patient at the facility.</p> <p>3. Staff member #7 indicated the following in interview beginning at 2:40 p.m.: (A) The facility would have to adhere to a request for a transfer if a request was made. (B) Social services would call the facility to see if they could accept the patient in transfer. If they could not, it would be documented in the medical record.</p> <p>4. Facility policy titled "DISCHARGE PLANNING" last reviewed/revised 4/09 states on page 3: "Social workers assist the patient and family in decisions regarding appropriate living arrangements; community services and supports; and any financial, legal, or social needs they may have....."</p>						

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