

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150044	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2015
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NAME OF PROVIDER OR SUPPLIER  FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 STATE ST NEW ALBANY, IN 47150
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S 0000  Bldg. 00	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00175788 Substantiated, State deficiency related to the allegations is cited.</p> <p>Facility Number: 005040</p> <p>Date: 6/29/15</p> <p>QA: cjl 07/02/15</p>	S 0000		
S 0912  Bldg. 00	<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</p>			

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>nursing personnel and staff necessary to provide care for all patient care areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(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 document review and interview, the nursing executive failed to ensure the implementation of facility policy regarding general safety and fall prevention for 4 of 10 patient records reviewed. (Patients #3, #6, #7, and #10.)</p> <p>Findings:</p> <p>1. Review of the policy "General Safety and Fall Prevention", policy number 600-1023, last revised on 2/21/14, indicated:</p> <p>a. Page two reads "1. Each patient will be assessed by the registered nurse on admission to determine if the patient is at risk for fall. 2. The nurse is to reassess each patient's fall risk at least every 12 hours or as a change occurs...3. Appropriate measures will be instituted,</p>	S 0912	<p>Plan of Correction</p> <p>Date Completed or Time line to Complete</p> <p>Person Responsible</p> <p>1. Department specific falls policy created for Emergency Department. At the time of initial assessment, yellow arm band will be placed on all patients assessed according to the Morse Fall Risk Scale to be a High Risk for Falls (45 or Greater. Reassessment and rescoring of the patient will occur anytime the RN deems necessary</p> <p>- Exhibit A</p>	08/01/2015

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	<p>based on patient need, as outlined in this procedure...".</p> <p>b. Page two reads that moderate risk for falls = 25 to 44, and a high risk for falls is "45 and higher".</p> <p>c. Page 3 reads: "1. Each patient is assessed on admission to the nursing unit for risk for fall by a RN (registered nurse) utilizing the Morse Fall Risk Assessment...".</p> <p>d. Page 6 reads: "7. Additional fall prevention strategies to implement if the patient is determined to be at high risk for falling are, but are not limited to the following:...B. Identify patient by applying yellow wristband &amp; yellow gown...c. Place a falling star outside of patient's room. d. Utilize bed alarm...".</p> <p>2. Review of patient medical records indicated:</p> <p>a. Pt. #3 had safety precautions noted on 3/14/15 while in the ED (emergency department). Per the medical record, the call system was in place, side rails were up x 2, and the bed position was low. No Morse fall risk score was performed for this patient prior to going to Ultrasound at 8:00 PM. When the patient went to Ultrasound, they stated they had fallen in the bathroom when changing clothes. The patient returned from Ultrasound at 9:30 PM with a hematoma over the right eye and an ice pack applied. The Morse</p>		<p>August 1, 2015</p> <p>Director of Emergency Services / Manager of Emergency Services</p> <p>2. Memorandum to ED Staff, including copy of new policy, implementation of mandatory Morse Fall Risk Scale assessment to be done at the time of presentation with read and sign to be returned to Director and Manager.</p> <p>- Exhibit B</p> <p>August 14, 2015</p> <p>Director of Emergency Services / Manager of Emergency Services</p> <p>3. ITS Department has modified EMR. The Morse Fall Scale will now be performed by the Triage RN in the ED (screen shot 1).</p> <p>There is now a "safety/fall" tab on the Triage report (screen shot 2)</p> <p>Live Falls and General tabs now show up in the ambulatory assessment reflecting a patient has been tagged as a high risk for falls (screen shots 3 and 4)</p> <p>A hard stop has been built in so the Morse Scale assessment must be completed before going forward in</p>	

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	<p>score at that time was 60 (high risk = &gt;44). There was no documentation that a yellow bracelet, to indicate the patient was a high risk for falling, or that a yellow gown was placed, prior to the patient's discharge from ED to home at 10:50 PM.</p> <p>b. Pt. #6 presented to the ED on 6/9/15 at 7:34 AM. Discharge was at 11:12 AM to home in stable condition with a discharge diagnosis of leg pain, hip contusion. There was no Morse fall risk assessment completed on this patient.</p> <p>c. Pt. #7, a 31 year old (pt. #6) who had been seen in the ED earlier on 6/9/15, later presented to the ED at 5:53 PM with "syncopal episodes". At 6:00 PM the Morse fall risk assessment indicated the patient scored at 20 (low risk). The patient fell at 9:00 PM and had no further Morse scoring done prior to admission to ICU (intensive care unit) at 12:40 AM on 6/10/15. The Morse score at 1:30 AM in ICU was 95, with no yellow wrist band or yellow gown noted as being provided.</p> <p>d. Pt. #10 was an 80 year old admitted to the ED on 5/15/15. There was no Morse fall risk scoring done while the patient was in the ED from 11:52 PM on 5/15/15 to admission at 5:30 AM on 5/16/15. The first Morse score was noted as done at 7:15 PM on 5/16/15, not at the time of admission to the unit, as per facility policy. (Score was 20--low risk</p>		<p>the charting (screen shot 5).</p> <p>– Exhibit C (screen shots 1 -5 )</p> <p>July 29, 2015</p> <p>Director of Information Technology Services (ITS)</p> <p>4. General Safety and Fall Prevention policy for inpatients was amended to include verbiage regarding reassessment of comatose patients. <b>Exception: Patients who are brain dead/ or comatose will not need to be assessed. Patients who are appropriately sedated and/or on paralytics will not need to be assessed, unless breakthrough agitation is noted.</b></p> <p>- Exhibit D</p> <p>July 27, 2015</p> <p>Director of Quality/ Chief Patient Safety Officer</p> <p>5. Monitoring will be conducted on a minimum 200 charts per month in the Emergency Department to ensure Morse Fall Risk Score was utilized, documented and the appropriate intervention occurred.</p> <p>Audit results will be shared at monthly staff meetings, Interdisciplinary Committee, and</p>	

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	<p>with patient on the ventilator.)</p> <p>3. At 3:00 PM on 6/29/15, interview with ED RN #54 indicated:</p> <p>a. The medical records, as listed in 2. above, were lacking documentation of having a Morse fall risk score performed and/or documentation of implementing high risk interventions for those who scored &gt;44.</p> <p>b. It was unknown if the EMR (electronic medical record) had a section for documenting the higher risk implementations, such as bed alarms, yellow wrist bands, yellow gowns, and falling stars.</p> <p>4. At 4:40 PM on 6/29/15, interview with ED RN #55 indicated a "secondary screen" is available for nursing staff to document the high risk for fall interventions, as required per facility policy.</p>		<p>Patient Quality and Safety Committee.</p> <p>Individuals who fail to assess or document appropriately will be counseled immediately. Deviations from the policy will result in initiating the progressive disciplinary process, beginning with a verbal warning up to and including termination.</p> <p>Audits will continued until 100% compliance is maintained for 90 days consecutively. Audits will then go to quarterly as long as 100% compliance is maintained.</p> <p>- Exhibit E</p> <p>August 1, 2015 through November 1, 2015 or as long as required to maintain 100% compliance</p> <p>Manager of Emergency Services</p>	