

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2011
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NAME OF PROVIDER OR SUPPLIER REID HOSPITAL & HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 REID PKWY RICHMOND, IN47374
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S0000	<p>This visit was for the investigation of a licensure complaint.</p> <p>Complaint: IN00083823 Substantiated, State deficiency related to allegation cited.</p> <p>Date of Survey: 10-24-11</p> <p>Facility number: 005044</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>QA: claughlin 11/15/11</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 interview, the facility failed to ensure that a registered nurse (RN) followed facility policy/procedures relating to hygiene and oral care for 4 of 4 medical records (MR) reviewed (patient #1, 2, 3 and 4).</p>	S0930	<p>1. Correcting deficiencyA. Updated Policy PM2-168 - oral care - completed 12/8/2011B. Reviewed Policy SNP-004-Standards of Nursing Practice-Hygiene. no changes necessary. - completed 12/8/2011C. Train/re-educate all</p>	11/24/2011

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>Findings include:</p> <p>1. Review of policy/procedure, Standards of Patient Care, indicated the following; "1. The nursing process shall be utilized as the basis for providing care to all patients. 9. An RN is in charge of the nursing unit and activities at all times. Care delivery for all patients shall include: C. Provisions for basic hygiene." This policy/procedure was last reviewed/revised on 06-02-10.</p> <p>2. Review of policy/procedure Standard No. 4, Hygiene will be maintained, indicated the following; "3. Provide opportunity for daily and prn hygiene and assist as needed." This policy/procedure was last reviewed/revised on 09/09.</p> <p>3. Review of policy/procedure Oral Care, indicated the following; "3. If the patient has dentures, ensure that the oral cavity is cleaned with antiseptic rinse after meals and dentures removed and rinsed of any food residue. Dentures shall be brushed twice a day and soak dentures nightly in effervescent denture cleaner. Documentation 1. Electronic Medical Record"</p>		<p>Geropsychiatric nursing staff on Policies - completed 12/19/2011.2. Preventing Recurrence A. Complete weekly random audits to ensure documentation of: - started immediately.1. Dentures brushed at least 1 time per day.2. Dentures soaked in effervescent denture cleaner nightly3. Daily Hygiene Completed B. Employees not in compliance will receive corrective action (Just Culture). C. Comprehensive audit results will be presented at monthly department meetings as part of regular QA report.Auditing started 12/19/2011. Results will be emailed to all staff on 12/28/11 then presented monthly at department meetings starting 1/25/2012.3. Responsible Persons: Lisa Suttle, Director of Psychiatric Services; Laura Sutphin, Geropsychiatry Unit Director.</p>		

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	<p>This policy/procedure was last reviewed/revised on 01-05-11.</p> <p>4. Review of patient #1's MR indicated the patient was admitted with Alzheimer's dementia with behavioral disturbance to the Geropsychiatric Unit on 10-21-10 and discharged on 11-24-10. The Nursing Admission Assessment indicated that the patient was alert and oriented x 1 and the patient had dentures. The patient's MR lacked documentation of daily hygiene care on 10-22-10 to 11-01-10, 11-03-10 to 11-12-10 and 11-14-10 to 11-18-10. The MR lacked documentation that the patient's dentures had been brushed twice a day and soaked nightly in effervescent denture cleaner.</p> <p>5. Review of patient #2's MR indicated the patient was admitted with Alzheimer's dementia with behavioral disturbance to the Geropsychiatric Unit on 10-05-11. The patient's MR indicates the patient had dentures. The patient's MR lacked documentation of daily hygiene care on 10-06-11 and 10-09-11 to 10-12-11. The MR lacked documentation that the patient's dentures had been brushed twice a day and soaked nightly in effervescent denture cleaner.</p> <p>6. Review of patient #3's MR indicated the patient was admitted to the</p>			

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	<p>Geropsychiatric Unit on 10-11-11. The patient's MR lacked documentation of daily hygiene care on 10-12-11, 10-15-11, 10-17-11 and 10-19-11.</p> <p>7. Review of patient #4's MR indicated the patient was admitted with Alzheimer's dementia with paranoia and aggressive behavior to the Geropsychiatric Unit on 09-24-11. The patient's MR lacked documentation of daily hygiene care on 09-24-11 to 09-29-11 and 10-02-11 to 10-03-11.</p> <p>8. On 10-24-11 at 1500 hours staff #44 confirmed that patient #2, 3 and 4's MR lacked documentation of hygiene and denture care.</p>				