

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2011
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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-BEECH GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 ALBANY ST STE 200 BEECH GROVE, IN 46107
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S0000	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00091826: Substantiated with deficiencies cited related to the complaint</p> <p>Date: 12/28/11 and 12/29/11</p> <p>Facility Number: 008900</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 01/13/12</p>	S0000		

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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S0912	<p>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 nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (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. (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 policy and procedure review, patient medical record review, and staff interview, the chief nursing officer failed to ensure the implementation of two facility policies for 4 of 4 patients (N1 through N4); failed to ensure the implementation of physician orders for 1 of 4 patients (N1); and failed to document wound care per instructions for two patients (N1 and N3).</p>	S0912	<p>1.S 912 410 IAC 15-15-6 Nursing Service 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)The Chief Nursing Officer (CNO) or designee has implemented the following plan of correction: Per policy P01-G: PAIN MANAGEMENT,</p>	02/15/2012
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	<p>Findings:</p> <p>1. at 11:32 AM on 12/28/11, review of the policy and procedure "Pain Management, Assessment and Intervention Protocol" (P01-G), indicated:</p> <p>a. on page 3 under "Procedure", it reads in section B. "All patients will be assessed for pain upon admission...2) If pain stated, patient will be assessed about every 4 hours..."</p> <p>b. under "Procedure", it reads in section J. "After the initiation of pain management therapy:</p> <p>1) Assess pain every two hours while patient is awake for the first 24 hours post-op. After the first 24 hours, pain will be assessed every four hours for the duration of the hospitalization..."</p> <p>2. review of patient medical records during the 12/28/11 and 12/29/11 survey process indicated:</p> <p>a. pt. N1 had documentation of pain assessments that were greater than every 4 hours on: 4/19/11, 4/23/11, 4/24/11, 4/28/11, 4/30/11, 5/1/11, 5/3/11, 5/6/11, 5/10/11, and 5/11/11</p> <p>b. pt. N2 had documentation of pain assessments that were greater than every 4 hours on: 4/21/11, 4/30/11 and 5/3/11</p> <p>c. pt. N3 had documentation of pain assessments that were greater than every 4 hours on: 3/31/11, 4/1/11 4/6/11, 4/13/11, 4/23/11, 4/24/11, 4/28/11 (a straight line was drawn through the hours of "20, 22, 24, 02, 04, and 06, but no pain score was written) and 5/14/11</p> <p>d. pt. N4 had documentation of pain assessments that were greater than every 4 hours on: 5/8/11, 5/9/11, 5/13/11, 5/14/11, 5/15/11, 5/16/11, 5/17/11, 5/20/11, 5/21/11, 5/22/11 and 5/23/11</p> <p>3. interview with staff members NA and NC at 11:30 AM on 12/29/11 indicated documentation, as per the facility policy, is lacking for pts. N1 through N4 as stated in 2. above</p>		<p>ASSESSMENT AND INTERVENTION. Pain assessments and reassessments will be conducted as per aforementioned policy. These assessments and reassessments will be documented in the 24 hour nursing flow sheet. Per policy F02 – G: FALL REDUCTION PROGRAM. Structured hourly rounding will be implemented immediately. The Charge Nurse (CN) for each shift will be responsible for assigning hourly rounds to staff members. Per policy D05 – G: Documentation Standards. Clinical staff will document in accordance with policy immediately which includes documentation of hourly rounding completed. Per policy O02 – G: Orders, Physician. Physician orders, especially as they relate to wound care instructions will be placed on the Kardex for communication to clinical staff. Clinical staff will utilize wound care documentation form to note all wound care treatments; adherence to physician orders. Nursing staff were re-educated to these policies during staff meetings scheduled from January 4, 2012 through February 17, 2012. This process is being</p>				

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	<p>4. at 12:05 PM on 12/29/11, review of the policy and procedure "Fall Reduction Program" (F02-G), indicated:</p> <p>a. on page one in the "Introduction" section, it reads: "...implement a structured approach for HOURLY ROUNDING..."</p> <p>b. on page 2 under "Policy", it reads in I. "Assessment of the patient", "...e. Documentation will be on a 24 Hour Nursing Flow Sheet f. In addition, there will be a structured approach to hourly rounding."</p> <p>c. on page 2 under "II. Standard Fall Reduction Strategies: Applicable to Every patient a. Hourly Rounding--must be structured, assigned and consistent..."</p> <p>5. review of patient medical records during the 12/28/11 and 12/29/11 survey process indicated:</p> <p>a. pt. N1 had hourly rounding that was not documented each hour on the 24 hour flow sheet on: 4/19/11, 4/23/11, 4/30/11, 5/2/11, 5/3/11, 5/4/11, 5/6/11, 5/9/11, 5/10/11, 5/11/11 and 5/12/11</p> <p>b. pt. N2 had hourly rounding that was not documented each hour on the 24 hour flow sheet on: 4/18/11, 4/21/11 and 4/30/11</p> <p>c. pt. N3 had hourly rounding that was not documented each hour on the 24 hour flow sheet on: 3/30/11, 3/31/11, 4/1/11, 4/6/11, 4/9/11, 4/13/11, 4/22/11, 4/23/11, 4/29/11, 5/1/11, 5/4/11, and 5/9/11</p> <p>d. pt. N4 had hourly rounding that was not documented each hour on the 24 hour flow sheet on: 5/13/11, 5/14/11, 5/15/11, 5/20/11, 5/21/11 and 5/22/11</p> <p>6. interview with staff staff members NA and NC at 11:30 AM on 12/29/11 indicated documentation, as per the facility policy related to hourly rounding, is lacking for pts. N1 through N4 as stated in 5. above (each hour is to be initialed</p>		<p>audited weekly by the CNO /DQM /or designee. The weekly audits will continue on 10 charts until a compliance of 90% has been sustained for 3 consecutive months. These audits will include documentation of hourly rounding, pain assessment/re-assessment, and execution of physician orders related to wound care. Random audits will be conducted from that point forward to monitor ongoing compliance. Non-compliant staff will be subject to the progressive disciplinary process. Results of audits will be reported at monthly Quality Assurance/Performance Improvement (QAPI) meeting. Resultant findings and/or actions will be reported by the DQM and/or designee quarterly to Organizational Improvement Committee (OIC), Medical Executive Committee (MEC) and the Governing Board (GB).</p>				

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	<p>by staff on the 24 hour flow sheet--at least one hour was missing on all of the days listed in 5. above, with whole shifts of 12 hours lacking documentation on some days)</p> <p>7. review of patient medical records during the 12/28/11 and 12/29/11 survey process indicated: a. pt. N1: A. had physician orders written on 4/17/11 for "alternating lynard splint and waffle boot every 2 hours". B. lacked documentation of alternating the lynard splint and the waffle boot every two hours on the following days: 4/17/11, 4/18/11, 4/19/11, 4/23/11, 4/29/11, 4/30/11, 5/1/11, 5/2/11, 5/3/11, 5/4/11, 5/5/11, 5/6/11, 5/7/11, 5/8/11, 5/9/11, 5/10/11 and 5/11/11 (other days the waffle boots and splint were mentioned as patient equipment, but not necessarily that they were alternated every two hours as physician orders dictated)</p> <p>8. interview with staff member NB at 3:40 PM on 12/29/11 indicated that this staff member went through the medical record, and daily flow sheets, for pt. N1 with the surveyor and confirmed the information in 7. above</p> <p>9. review of patient medical records during the 12/28/11 and 12/29/11 survey process indicated: a. pt. N1 had: A. a physician order on 4/17/11 for "M-9 odor eliminating drops to ostomy" that lacked any documentation or indication through out the medical record that this order was implemented by nursing staff B. a "Wound Documentation" form with instructions to change an abdominal dressing on "Mondays, Wednesdays and Fridays" that was lacking documentation of a dressing change on Wednesday, 5/4/11 (last documented day of wound care was 5/2/11 (Monday)</p>			

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	<p>C. physician orders on 5/6/11 to: "1. discontinue NWPT (negative pressure wound vac therapy) 2. Begin cleanse abd. (abdominal) wound with NS (normal saline), apply hydrogel moistened gauze, cover with dry 2x2 change qd (every day)"--No wound documentation form was created--it could not be determined that this new daily wound care order was implemented between the order date of 5/6/11 and the discharge date of 5/12/11</p> <p>b. pt. N3 was lacking documentation of "wound 2"--"buttocks" care for the days between 5/1/11 and 5/12/11 on the "wound documentation" form (page 2) --there are also no signatures/documentation of wound care on this form on 4/29/11, 5/16/11 and 5/20/11 (instructions on the form were for daily dressing changes)</p> <p>10. at 3:10 PM and 3:25 PM on 12/29/11, interview with staff member NF indicated:</p> <p>a. this staff member is unclear why a new wound documentation form was not started for pt. N1 with the new order on 5/6/11 for daily dressing changes--no form could be found related to the new order</p> <p>b. there is no documentation for record N1 that would indicate the 4/17/11 order for the M-9 odor eliminating prescription was followed</p> <p>c. it was thought that perhaps the wound documentation form for pt. N3 for the days of 5/1/11 to 5/12/11 were misfiled in another patient's chart--none were found for pt. N3 to indicate that daily dressing changes occurred between those dates, as stated in 9. b. above.</p>						