

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER TERRE HAUTE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S SEVENTH ST TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000000	<p>This visit was for the investigation of one State hospital complaint.</p> <p>Complaint # IN00124182 Substantiated: A deficiency unrelated to the allegations is cited.</p> <p>Facility #: 005042</p> <p>Date: 03-14-13</p> <p>Surveyor: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor</p> <p>QA: clauglin 04/16/13</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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S000294	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (c)</p> <p>(c) The governing board is responsible for managing the hospital. Based on document review and interview, the governing board failed to ensure 2 approved facility policies were followed (Fall Precautions and Do Not Resuscitate).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of facility policy titled FALL PRECAUTIONS, last revised 2-2012 indicated the following: An occurrence report will be filed by the nurse who was caring for the patient at the time of a fall; under Post Fall Notification and Documentation, the policy indicated the following: Complete occurrence report. Review of the medical record of P#1 on 03-14-13 indicated a fall occurred on 11-10-12 at 1558 hours in the patient's room. Review of facility incident reports on 03-14-13 lacked evidence an incident/occurrence report was completed for P#1 following an unwitnessed patient fall on 11-10-12 at 1558 hours in the patient's hospital room. An interview with B#4 was conducted on 03-14-13 at 1330 hours and confirmed P#1's medical record indicated the patient 	S000294	<p><u>Discussion:</u> The Governing board failed to ensure two approved facility policies were followed (Fall Precautions and Do Not Resuscitate). <u>Corrective Action:</u></p> <ol style="list-style-type: none"> (a) Policy, IPC.ETH.005, Do not Resuscitate (DNR) and Physician Orders for Scope of Treatment (POST), was reviewed by the VP of Quality Management, Quality Manager, and Chief Nursing officer on March 14, 2013 and no revisions were necessary. The policy states that once a DNR discussion is completed, the attending physician will document the substance of the discussion in the patient's medical records. See Attachment 1.(a) An email was sent to all Nursing Staff and the Governing body by the Regulatory Survey Coordinator on May 6, 2013 outlining the requirements of Policy, IPC.ETH.005. Any discussion of DNR with a patient or his/her representative must be documented in the patient's medical record. See Attachment 2. A memo on the same subject was sent to Terre Haute Regional Hospital Medical staff on May 6, 2013. See Attachment 3. (b) Policy, IPC.SAF.005, Fall Precautions, was reviewed by the VP of Quality Management, 	05/07/2013			

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	<p>fell to the floor on 11-10-12 at 1723 hours; B#4 confirmed the facility policy requires an incident/occurrence report be completed for all falls; B#4 confirmed there is no documentation an incident/occurrence report was completed for P#1.</p> <p>5. Review of the facility policy titled DO NOT RESUSCITATE (DNR) AND PHYSICIAN ORDERS FOR SCOPE OF TREATMENT, last approved 3-2-10 indicated the following: If a DNR order is considered medically appropriate, the attending physician will assess the patient's decision-making capacity and determine if the patient has a written Advance Directive. If no such directive exists, the physician shall discuss the order with the patient or the patient's representative if the patient is incompetent. After the DNR order discussion is completed, the attending physician will document the substance of the discussion in the patient's medical records.</p> <p>6. Review of the medical record of P#1 on 03-14-13 lacked documentation of a discussion between P#1 and his/her physician related to Do Not Resuscitate (DNR) status prior to the DNR order.</p> <p>7. An interview was conducted with B#5 on 03-14-13 at 1345 hours and confirmed the medical record of P#1 lacked documentation of a discussion of the</p>		<p>Quality Manager, and Chief Nursing officer on March 14, 2013 and no revisions were necessary. The policy states that an occurrence report will be filed by the nurse caring who was caring for the patient at the time of the fall and that a fall is defined as an unplanned decent to the floor or an extension of the floor, with or without injury to the patient. See Attachment 4.</p> <p>(b)Education was provided to all nursing staff on April 30, 2013 by the Regulatory Survey Coordinator via email and unit notices. This education was to re-enforce the requirement that nurses complete an occurrence report for any fall as well as the hospital definition of a fall. See Attachment 5. <u>Compliance Monitoring</u> (a) A random sample of 20 patients with Do Not Resuscitate (DNR) orders in the Medical record will be evaluated monthly times 3 months by the Regulatory Survey Coordinator to ensure that discussion between the Physician and patient/ caregiver has been documented in the medical record. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment 6. (b) 100% of all falls will be reviewed for correct and thorough completion of the occurrence report according to Hospital Policy by the Risk Manager</p>				

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	DNR status between the patient and the physician signing the DNR order; B#5 confirmed the facility policy requires a discussion of the status change between the physician and patient and that the discussion be documented in the patient's medical record.		monthly times 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment 7. Implementation Date: May 7, 2013 Responsible Person:(a) Chief Nursing Officer, Vice President of Quality, and President of the Medical Staff.(b) Chief Nursing officer and Directors of all Patient care Units.		