

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERCREST SPECIALTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1625 E JEFFERSON BLVD MISHAWAKA, IN 46545
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S000000	<p>This visit was for investigation of two hospital licensure complaints.</p> <p>Complaint Numbers:</p> <p>IN00116571: Substantiated with deficiencies cited not related to the complaint</p> <p>IN00122509: Unsubstantiated for lack of sufficient evidence with deficiencies cited not related to the complaint</p> <p>Date: 4/30/13 and 5/1/13</p> <p>Facility Number: 012130</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 05/28/13</p>	S000000		
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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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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. The governing board failed to ensure the CPR (cardiopulmonary resuscitation) competence of staff, as required per the job descriptions, for 1 of 2 LPNs (licensed practical nurses), staff member P1, and for 1 of 3 CNAs (certified nursing assistants), staff member P5.</p> <p>Findings: 1. at 3:45 PM on 5/1/13, review of the job descriptions for LPNs and CNAs indicated: a. for "Job Title: Licensed Practical Nurse", it reads under "Requirements": "...Licensure:...CPR certification within 90 days of hire..." b. for "Job Title: Nurse Aide", it reads</p>	S000318	<p>Job description of Nurse Aid and License Practical Nurse CPR certification was reviewed and updated to read having CPR certification of 90 days upon hired. A report of upcoming CPR expirations will be emailed out to nurse managers to catch upcoming CPR expirations. These employees will then be enrolled in a CPR class. An additional CPR class was added to catch up outdated CPR employees. Date of completion July 1, 2013. Erica Wertanen, Human Resource director is responsible.</p>	07/01/2013			

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	<p>under "Requirements":</p> <p>"...Licensure:...CPR certification within 60 days of hire."</p> <p>2. at 3:10 PM on 5/1/13, review of employee files indicated:</p> <p>a. staff member P1 was a LPN hired 12/20/10 whose file had a copy of a CPR card that expired 11/12</p> <p>b. staff member P5 was a CNA hired 10/14/08 whose file had a copy of a CPR card that expired 2/13</p> <p>3. interview with staff members #54, the charge nurse, and #55, the director of nursing, at 3:20 PM on 5/1/13, indicated:</p> <p>a. a current CPR card for staff member P1 was not found</p> <p>b. staff member P1 left employment at this facility on 2/14/13, but had an expired CPR competency for almost 3 months prior to leaving.</p> <p>c. staff member P5 is signed up to take CPR recertification on May 7, 2013, but is already 2 months lapsed in CPR competency</p> <p>d. there is currently no monitoring of when staff CPR certification is due to expire</p> <p>e. a change in personnel occurred in the Fall of 2012 and a new human resource person was put in place, coordination with this staff member is needed to put a monitoring system into place</p>			
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	<p>f. nursing supervisors have some CPR information for staff and human resources have some of the CPR information for staff, but there is no coordinated effort in maintaining staff competencies</p> <p>g. there is no "grace" period for a gap in CPR certification, it is expected that staff will maintain this competency</p> <p>h. both staff members, P1 and P5, "fell through the cracks" in maintaining their competencies for CPR certification and were not monitored by either human resources, or nursing administration for this requirement</p>				

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S000912	<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 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 nurse executive failed to ensure that nursing staff followed physician orders and facility policy related to the administration of medication for two patients (pts. #3 and #4); failed to follow</p>	S000912	<p># : Daily Weights o Attached copy of RiverCrest Form# 171-RC: o Monitor &amp; Sustain: Will complete random graphic record audits on five (5)</p>	07/01/2013			

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	<p>physician orders related to daily weight checks for two patients (pts. #3 and #6); failed to follow facility policy related to IV (intravenous) site checks every two hours for 4 patients (pts. #3, #4, #5, and #6); failed to implement the fall prevention policy for one patient with two falls (pt. #3); and failed to follow facility policy and standard of practice after the administration of medication for complaints of pain for 3 patients (pts. #1, #2, and #3).</p> <p>Findings:</p> <p>1. at 3:05 PM on 5/1/13, review of the policy and procedure "General Medication Administration", policy number II.C.88, with a most recent revised date of 11/2011, indicated:</p> <p>a. under "Policy", it reads: "Medications will be administered only upon the order of physicians,..."</p> <p>b. under the 6th bullet point on page 3, it reads: "...If a medication is held or refused, a notation will be made on the patient's medication administration record (MAR)..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #3 had practitioner orders written on 4/10/12 for Nuedexta daily, but the MAR (medication administration record) lacks documentation by nursing of the administration of this medication on both 4/14/12 and 4/15/12</p> <p>b. nursing failed to document on the MAR for patient #3 if the medication was held or refused</p> <p>c. pt. #4 had practitioner orders on 11/17/12 for Unasyn 1.5 gm IV every 8 hours and lacked documentation of administration at the 11:00 AM time frame for dosing on 11/18/12 (nurse initialed and then crossed their initials out)</p> <p>d. pt. #4 had practitioner orders written on 11/17/12 for Fluconazole 200 mg daily, but lacked documentation of the administration of the medication on 11/18/12 (the nurse's initials are circled and without explanation of this notation)</p>		<p>open charts per month for completeness of documentation</p> <p>o Education of Staff: Nursing staff received remedial education at the June staff meeting to continue to complete the daily graphic record; specifically to no blanks on form.</p> <p>·#: IV Site Checks</p> <p>·Attached copy of revised policy # C-6 "<u>Intravenous Therapy</u>" revised areas highlighted yellow coincide with verbiage on 'IV Flow Sheet' for documentation.</p> <p>·Monitor &amp; Sustain: Will add an audit of the IV Flow Sheet to the monthly Clabsi Data collection tool.</p> <p>·Education:</p> <p>·Nursing RN/LPN staff will sign memo of understanding verifying review and understanding of this policy update.</p> <p>·Nursing staff received education at the June staff meeting on policy and documentation requirement.</p> <p>·Completion date July 1, 2013</p> <p>·# Fall Prevention Plan</p> <p>·Attached copy of revised policy # <u>II-A-7 Fall Prevention Protocol</u>. Revised areas highlighted in yellow.</p> <p>·Attached copy of revised</p>				

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	<p>e. nursing failed to document on the MAR for patient #4 if the medications (Fluconazole and Unasyn) were held or refused</p> <p>3. interview with staff member #54, the charge nurse, at 3:05 PM and 3:30 PM on 4/30/13, indicated:</p> <p>a. after researching the medical record of pt. #3, it was determined that there was no "stop" or "hold" order related to the Nuedexta</p> <p>b. nursing staff failed to document on the MAR the administration of Nuedexta on 4/14/12 and 4/15/12</p> <p>c. it is unknown why the nurse crossed out their initials on the MAR for pt. #4 on 11/17/12 with the medication Unasyn</p> <p>d. it is unclear why the nurse circled their initials in the MAR for the Fluconazole due on 11/18/12</p> <p>4. review of patient medical records indicated patients # 3 and #6 had orders on admission for daily weights, but lacked documentation of weights as follows:</p> <p>a. pt. #3 lacked documentation of a daily weight on: 4/6/12; 4/9/12; 4/14/12; 4/29/12; and 4/30/12</p> <p>b. pt. #6 lacked documentation of a daily weight on 12/2/12</p> <p>5. interview with staff member #52, the chief clinical officer, at 2:20 PM on 5/1/13, indicated:</p> <p>a. daily weights were not performed/documented as ordered for pts. #3 and #6 as written in 4. above</p> <p>6. at 3:10 PM on 5/1/13, review of the policy and procedure "Intravenous (IV) Therapy" policy number II - C.6, with an issued date of 9/2009, indicated:</p> <p>a. under section "G. IV Site Inspection:", it reads: "i. All IV sites should be evaluated every 2 hours for evidence of cannula related complications, location and integrity of site...iv.</p>		<p><u>"Nursing Trifold"</u>. Changes highlighted in yellow.</p> <ul style="list-style-type: none"> <li>· Clarification of Fall Champion Team meeting-reported at facility quarterly QA meetings</li> <li>· Monitor &amp; Sustain: Monthly audit of all Falls as part of nursing's quality improvement process. Reported quarterly at facility QA meeting.</li> <li>· Education: <ul style="list-style-type: none"> <li>· All nursing staff will sign memo of understanding verifying review and understanding of this Fall policy and documentation requirements. Completion date of 06-24-2013</li> </ul> </li> <li>· # Medication Administration <ul style="list-style-type: none"> <li>· Reviewed Policy # II-C-88.</li> <li>· Added annual review of medication administration policy and procedure with written quiz.</li> <li>· Monitor and Sustain: Random monthly audits of MAR records of current open charts with staff remedial education as needed.</li> <li>· Completion date July 1, 2013</li> </ul> </li> <li>· # Pain Assessment <ul style="list-style-type: none"> <li>· Attached copy of revised policy # IIA-6 <u>"Pain Assessment and Management"</u>. Revised</li> </ul> </li> </ul>				

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	<p>Document IV assessment every 2 hours on Patient Care Flow Sheet, Intravenous Therapy Section..."</p> <p>7. review of patient medical records indicated:</p> <ul style="list-style-type: none"> <li>a. pt. #3 lacked documentation of an IV site check at 6 PM on 4/29/12 on the green and white "IV Flow Sheet" form</li> <li>b. pt. #4 lacked documentation of an IV site check at 8 AM, 10 AM, 12 PM, 2 PM, 4 PM, and 6 PM on 11/18/12 and at 8 AM, 10 AM, and 12 PM on 11/20/12 on the green and white "IV Flow Sheet" form</li> <li>c. pt. #5 had two liters of IV fluids on 11/4/12 and lacked documentation of IV site checks while the IV's were infusing as there was no green and white IV Flow Sheet in the patient's record</li> <li>d. pt. #6 lacked documentation of an IV site check at 4 PM and 6 PM on 11/30/12</li> </ul> <p>8. interview with staff member #54, the charge nurse, at 2:45 PM on 5/1/13 indicated:</p> <ul style="list-style-type: none"> <li>a. pt. #5 had no IV Flow Sheet as the IV's were not a continuous order, but for two units/liters only</li> <li>b. staff should have implemented an IV flow sheet for pt. #5 to ensure the competency of the site during infusion</li> <li>c. nursing failed to document 2 hour IV checks as listed in 7. above</li> </ul> <p>9. at 9:45 AM on 5/1/13, review of the policy and procedure "Fall Prevention Protocol", policy number II - A.7, with a last revised date of 8/2011, indicated:</p> <ul style="list-style-type: none"> <li>a. on page two in section "IV Assessments", it reads: "a. Complete fall scale every 8 hours on tri-fold..." (attached was a form titled Morris (sic) Fall Risk Scale)</li> <li>b. on page two in section "V. Interventions", it reads: "...b. High Risk Fall Prevention Interventions i. Hourly rounds to check for pain, toileting needs and position needs Verify</li> </ul>		<p>section to state that nursing will assess for pain/comfort every 2 hours.</p> <ul style="list-style-type: none"> <li>·See attached Trifold (form # clinical 160-RC) revision: section for pain documentation.</li> <li>·Education: <ul style="list-style-type: none"> <li>· All RN/LPN staff will sign memo of understanding verifying review and understanding of this Pain policy and documentation requirements. Completion date of 06-24-2013</li> </ul> </li> </ul> <p>Nika Taylor, Nurse manager is responsible.</p>	

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	<p>equipment such as bed alarms and chair alarms are on and functional...xxvi. Continue with follow up on needs of patients by addressing at post fall meeting and xxvii. Fall team to meet monthly..."</p> <p>c. on page 5 under section "VIII. Evaluation", it reads: "...b. Meet post falls to discuss what is working and what needs to be changed..."</p> <p>10. review of patient medical records indicated that pt. # 3 had a fall on 4/10/12 and again on 4/26/12 and:</p> <p>a. lacked the form: Morse Fall Risk Scale</p> <p>b. lacked documentation of hourly rounding that would "verify equipment such as bed alarms...", etc.</p> <p>11. interview with staff members #55, the director of nursing, and #54, the charge nurse, at 9:45 AM and 10:00 AM on 5/1/13, indicated:</p> <p>a. the policy statement to "complete fall scale every 8 hours on tri-fold" is incorrect as the tri-fold does not contain an area for fall assessment</p> <p>b. the policy is not clear that the Morse scale risk assessment is only to be done after a patient fall, and for any subsequent falls</p> <p>c. pt. #3 had two falls in Aprils 2012 and lacks two of the Morse scale risk assessments that should have been completed by nursing staff (one after each fall event)</p> <p>d. there is no fall team that meets monthly and there is no post fall meeting occurring for patients (documentation is noted on the incident reports, but there is no "meeting")</p> <p>e. the Fall Prevention policy needs to be "updated and clarified" to reflect what is actually occurring related to fall prevention, assessment, reassessment, and follow up after patient falls</p> <p>f. it is unclear how nursing is to "verify" hourly rounding on patients to assure safety when this is not documented in the medical records</p>			

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	<p>12. at 8:50 AM on 5/1/13, review of the policy and procedure "Pain Assessment and Management", policy number II - A.6, with an issued date of 11/07, indicated:</p> <p>a. under "Procedure", it reads: "...2. Initial Pain Assessment - completed initially by the admitting Registered Nurse using the FACES Scale or the 0 - 10 Scale. 3. Continuous Pain Assessment and Effectiveness of Interventions..."</p> <p>13. review of patient medical records indicated:</p> <p>a. pt. # 1:</p> <p>A. had nursing notes on 3/27/12 at 2:00 AM that read: "PRN (as needed) Morphine administered, pt grimacing, yelling out..."</p> <p>B. had nursing notes on 3/27/12 at 4:00 AM that read: "Pt has been making some repetitive sound constantly. Tried to hit staff uncooperative and restless"</p> <p>C. lacked documentation of effectiveness of the pain medication given at 2:00 AM</p> <p>b. pt. #2:</p> <p>A. had nursing notes on 3/21/12 at 10:00 PM that read: "c/o (complaining of) pain to...back. med given..."</p> <p>B. on the tri-fold form in the "Pain Assessment q 4 Hours" section, nursing noted a "Time of Reassessment" at 11:00 PM, but there is no documentation of whether the pain was relieved or what the score was upon reassessment (on the tri-fold, the pain at 10 PM was noted as "6/10")</p> <p>C. on the MAR and the tri-fold for 3/29/12, the patient is noted as receiving pain medication for back pain at 8:15 PM that scored "6/10", but there is no reassessment noted on the tri-fold and only a note at 10 PM that Zofran was given for nausea</p> <p>D. at 6:50 AM and 8:00 PM on 3/30/12, nursing noted on the tri-fold that pain medication was given for back pain scoring "9/10", but lacked</p>			

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	<p>documentation of a reassessment of the medication administration</p> <p>c. pt. #3:</p> <p>A. on 4/10/12, nursing documented on the tri-fold that pain medication was given at 9:00 PM for back pain at a level of "6/10" and had reassessment documented at 9:30 PM, but lacked a pain score that would indicate any relief the patient might have had</p> <p>B. on 4/12/12, nursing notes read at 3:35 AM: "PRN Norco administered for c/o back pain."; at 5:13 AM it was noted: "PRN Morphine administered for c/o severe back pain not relieved with Norco..."; and at 6:00 AM on 4/12/12, nursing wrote: "States pain is not relieved..."</p> <p>14. at 8:50 AM on 5/1/13, interview with staff members #55, the director of nursing, and #54, the charge nurse, indicated:</p> <p>a. since the tri-fold does not have an area to note the patient's pain score at the time of reassessment, it cannot be determined that pain medications were effective for patients as listed in 13. above</p> <p>b. nursing notes two hours after pain medication is given is considered OK at this facility, as a follow up time to reassess a patient, rather than the one hour standard of practice for pain follow up</p> <p>c. nursing is not addressing pain assessment with all of the two hour documentation so it cannot be determined that pain was decreased or relieved with medications given</p> <p>d. "pt. #3 was confused and not a reliable historian" when nursing documented on 4/12/12 the failure of effectiveness of the Norco and Morphine in relieving the patient's pain, and negated the fact that the patient reported severe back pain even after both meds were given</p> <p>e. the pain policy is vague in giving nursing staff direction as to expectations for the "reassessment of effectiveness" of pain</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERCREST SPECIALTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1625 E JEFFERSON BLVD MISHAWAKA, IN 46545
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(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
	<p>interventions</p> <p>f. hourly rounding, to check pain, positioning, and toileting, is performed by nursing staff but not documented in the the medical record</p> <p>g. the forms used to note hourly rounding are destroyed after approximately one month, once the director of nursing has reviewed them (they are not a part of the patient chart)</p>			