

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2015
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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
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S 0000 Bldg. 00	<p>This visit was for the State investigation of a complaint.</p> <p>Complaint #IN00173094 Substantiated, State deficiency related to allegations cited.</p> <p>Date of Survey: 09-01-15</p> <p>Facility Number: 009443</p>	S 0000		
S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <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</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>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, observation, and interview, the nurse executive failed to ensure nursing policy & procedures (P&P) were followed for keeping call lights within patient reach for 2 of 4 patients observed (Rooms 409 & 417), for repositioning of 1 patient (Pt#2), and for pain assessment of 1 patient (Pt#2).</p> <p>Findings:</p> <p>1. Review of P&P F02-G, titled Fall Reduction Program, indicated the following: Standard Fall Reduction Strategies: Individualized as applicable to every patient...Call light within reach. The P&P was last revised 4/15.</p> <p>2. On 9/1/15 during tour of inpatient units, beginning at 11:30am, in the presence of A3, Infection Control Nurse, and A4, Quality/Risk Manager, 4 rooms were spot checked for placement of call lights. It was observed that the call light</p>	S 0912	<p>Below is the action plan for complaint # IN00173094. Please see the copy of the email we received from your department dated 11-23-15 showing evidence of the date of notification of survey 1UY311. This email has been uploaded as supporting documents. What: The clinical staff including all nurses, certified nursing assistants, respiratory therapists, physical therapists, occupational therapists, and speech therapists will be re-educated on Policy F02-G Fall Reduction Program to include the importance of having the call light within reach, and Policy WC I-1 Wound Prevention to ensure that patients that are bed bound or with limited activity should be repositioned at least every two hours. This education will include the evidence based practice of utilizing a turning schedule as well as the use of foam wedges or pillows to protect bony prominences. The Nursing staff will be re-educated on Policy P01-G Pain Management</p>	12/23/2015

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	<p>in room 409 was hanging on the wall behind the bed, out of the patient's reach, and the call light in room 417 was hanging on an infusion pump pole, out of the patient's reach.</p> <p>3. On 9/1/15 at 12:30pm, A4 indicated the call lights were likely placed out of reach during patient care and should have been returned to the patient prior to staff leaving the room. At 4:10pm A4 indicated pain assessment prior to administration of a pain medication would be documented in the MR on the pain scale or in the nursing narrative.</p> <p>4. Review of the P&P WC I-1, titled Wound Prevention, indicated the following: Patients that are bed bound or with limited activity should be repositioned at least every two hours. Foam wedges or pillows should be used to protect bony prominences. The P&P was last revised 10/1/14.</p> <p>5. Review of the P&P P01-G, titled Pain Management, Assessment, and Intervention Protocol, indicated the following: Pain is a subjective response with several quantifiable features including intensity, time course...The pain assessment tool will be utilized...to indicate pain on a scale from 0-10. The FLACC (Face, Legs, Activity, Cry,</p>		<p>Assessment and Intervention Protocol to include the processes to prevent, assess, diagnose, treat and evaluate the multidimensional aspects of pain. Who: The Chief Nursing Officer will be responsible for the re-education. How: 1. The Chief Nursing Officer will audit a total of 20 rooms per month for compliance of the call light being within reach. This will be audited until a goal of 100% is reached for four months. Non compliance may result in disciplinary action up to termination of employment. Results will be reported in monthly Quality Assessment and Performance meeting, and quarterly in Organization Improvement Committee, Medical Executive Committee and Governing Board. 2. The Director of Quality Management will audit 5 charts per week for a total of 20 charts per month to ensure documentation of the skin prevention bundle which includes repositioning is documented every shift. This will be audited until a goal of 100% is reached for four months. Non compliance may result in disciplinary action up to termination of employment. Results will be reported in monthly Quality Assessment and Performance meeting, and quarterly in Organization Improvement Committee, Medical Executive Committee and Governing Board. 3. The Chief Nursing Officer will audit 5 charts</p>				

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	<p>Consolability) scale will be used for patients who are unable to communicate. The P&P also indicated that a patient report of "4" or more (on the 0-10 scale) will receive some type of intervention. The P&P was last revised 10/1/10.</p> <p>6. Review of Pt#2's medical record (MR) indicated in the Patient Assessment Report/Skin Prevention Bundle, reposition every 2 hours, but it could not be determined what times the patient was turned, in what position the patient was placed, or if foam wedges or pillow were used. The Nurse Progress & Narrative Notes of the MR indicated on 3/29/2015 at 06:31hrs, the patient was resting in bed, was given Tylenol for pain, and was given Ativan for anxiety. The Nursing - Pain Assessment Detail documentation of the MR indicated pain assessments of 0 (0-10 scale and non-verbal scale) on 3/29/15 at 01:00hrs, 13:20, & 23:46hrs. The MR lacked documentation of pain assessed at "4" or more at the time pain medication was given.</p> <p>7. On 9/1/15 at 12:00pm A3, Infection Control Nurse, indicated turning the patient every 2 hours is protocol and is indicated in the medical records by the end of shift statement in the Skin Prevention Bundle that states "Turn and reposition every 2 hours". A3 indicated</p>		<p>per week with a total of 20 charts per month for compliance of pain assessment, re-assessment, administration and documentation. This will be audited until a goal of 100% is reached for four months. Non compliance may result in disciplinary action up to termination of employment. Results will be reported in monthly Quality Assessment and Performance meeting, and quarterly in Organization Improvement Committee, Medical Executive Committee and Governing Board.</p>				

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	<p>actual times of when this is done or in what position the patient is left at what time cannot be determined.</p> <p>8. On 09/01/15 at 3:15pm, A2, Chief Nursing Officer, indicated nursing protocol is for patients to be turned every two hours. A2 indicated the MR does not show specific times of patients being turned, the position in which they are turned, or if wedges/pillows are used during repositioning.</p>			