

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2013
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NAME OF PROVIDER OR SUPPLIER SCOTT MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1451 N GARDNER ST SCOTTSBURG, IN 47170
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S000000	<p>This visit was for the investigation of one (1) State complaint at a Critical Access Hospital.</p> <p>Date of survey: 4/15/13</p> <p>Facility number: 004778</p> <p>Complaint number: IN00125493 Unsubstantiated; unrelated deficiency cited.</p> <p>Surveyor: Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/19/13</p>	S000000	<p>Complaint Number: IN00125493 unsubstantiated; Unrelated Deficiency action plan submitted. Dawn Mays RN, MBACHief Nursing Officer Scott Memorial Hospital</p>	
S000930	<p>410 IAC 15-1.5-6 NURSING SERVICE 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 staff interview, the facility failed to ensure the registered nurse followed physician orders for 1 of 5 patients (patient #2).</p>	S000930	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. o A review of the patient's episode of care was completed. This included the</p>	05/02/2013

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 patient #2 medical record indicated the following: (A) An order was written at 11:00 a.m. on 4/13/13 for neuro checks every shift. The medical record lacked documentation of a neuro check on dayshift on 4/13/13.</p> <p>2. Staff member #4 verified the medical record information for patient #2 at 2:20 p.m. on 4/15/13.</p>		<p>course of the care, the plan of care documentation, the goal achievement, the progress the patient made toward discharge, the successful to discharge from the acute level of care. No ill effects to the patient occurred because of the late initiation of neuro checks. o SMH Human Resource disciplinary policy was followed for nurse regarding the delay in taking off the neuro check order and performing the neuro checks on the patient. This included the hand-off of the information to the next shift. The nurse failing to implement the neuro check in a timely manner was counseled on May 2, 2013. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. o We reviewed the client care delivered to patients with diagnoses of cerebral effects. The diagnoses included stroke, trans-ischemic attack, change in level of consciousness, delirium, and drug overdose. o A check for neuro check intervention and the resultant timing and documentation of the neuro checks was noted. o Information on the review was used in the staff training and re-education. 3. Describe the steps or systemic changes the</p>		

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			<p>facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <ul style="list-style-type: none"> o Reviewed P&Ps o Instituted clearer verbiage in the P&P for when the order is taken off and the timing of initiation according to the standard of care and/or direct order. o Inservice for nursing staff which included: <ol style="list-style-type: none"> 1. Review of revised policy on physician orders. 2. All staff members have access to the policy through a shared drive. Communication of the training components included in the staff proceedings. 3. Information obtained from the review of patient records in which neuro checks were required and carried out – orders taken off and implementation timing, documentation. 4. Re-educated staff on use of SBAR for reporting all information regarding patient care. 5. Set clear expectation regarding physician orders and implementing the orders in timely manner and communicating this important order to the next shift. Set clear expectation that the nurse signing off the physician order is responsible for adding the neurological assessment to the worklist per physician order. 6. Set clear consequence of not carrying out and documenting physician orders in appropriate time. 7. Reviewed the SMH Human Resources Disciplinary 	

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			<p>Policy. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. o Director of Medical/Surgical Services is responsible for monitoring o A monthly, for three months, random medical record review of patients having neuro checks ordered ensure the staff is following the policy and that the order take off and documentation of implementing the neuro checks per physician order. Spot check will be completed in six month intervals for one year. o Information on the monitoring will be shared with the Quality and Patient Safety Committee (meets quarterly). Monitoring includes the actual performance, goal of 95%, and consequence steps if not met. Respectfully Submitted By: Dawn Mays RN, MBA Chief Nursing Officer Scott Memorial Hospital</p>		