

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/14/2011
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN47303		
(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	
S0000	<p>This visit was for investigation of one hospital licensure complaint.</p> <p>Complaint Number: IN00091673 Substantiated: deficiencies cited related to the complaint</p> <p>Date: 9/14/11</p> <p>Facility Number: 005079</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 10/20/11</p>	S0000	No dispute		

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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S0536	<p>410 IAC 15-1.5-1 (d)(1)(2)(3)</p> <p>(d) Menus shall meet the needs of the patients as follows:</p> <p>(1) Therapeutic diets shall be prescribed by the practitioner responsible for the care of the patient.</p> <p>(2) Nutritional needs shall be met in accordance with recognized dietary standards of practice and in accordance with the orders of the responsible practitioner.</p> <p>(3) A current therapeutic diet manual approved by the dietitian and medical staff shall be readily available to all medical, nursing, and food service personnel.</p> <p>Based on patient medical record review and interview, the facility failed to ensure the nutritional needs of 3 of 5 patients while in the ED. (N1, N4 and N5)</p> <p>Findings:</p> <p>1. review of patient medical records on 9/14/11 indicated:</p> <p>a. pt. N1:</p> <p>A. was admitted to the ED at 4:42 PM on 5/12/11</p> <p>B. had an order for a breakfast try entered into the computer system at 4:28 AM and 7:58 AM on 5/13/11</p> <p>C. was discharged at 6:25 PM on 5/13/11</p> <p>D. lacked documentation in the medical record of having received food trays at any time through out the 26 hours in the ED</p> <p>b. pt. N4:</p> <p>A. was seen in the ED at 10:30 PM on 5/8/11</p> <p>B. was noted by nursing at 7:30 AM on 5/9/11 as: "Taking food Well, Taking Oral Fluids</p>	S0536	EDS-31-P Emergency Department Standard of Patient Care and Patient Flow has been revised to include the statement: "If patient is allowed to have oral intake, document any meal or snack provided by dietary, nursing or person(s) with the patient. If patient is in the ED for an extended period of time and over a normal meal time and if the patient is allowed to eat, a meal or snack should be offered"Monitoring of the documentation of the offering of food for these patients will occur during the monthly patient tracers. October 2011 - 3 of 3 100% November 2011 - 3 of 3 100%The Nurse Manager is responsible for implementatio, monitoring and corrective action.	10/13/2011	

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	<p>Well,...breakfast tray to pt."</p> <p>C. had nursing documentation on 5/9/11 at 2:28 PM of "given graham crackers sierra mist and peanut butter per [pt] request"</p> <p>D. lacked any documentation of a noon meal being provided to the patient</p> <p>E. was discharged at 3:28 PM on 5/9/11</p> <p>c. pt. N5:</p> <p>A. was seen in the ED at 7:00 PM on 5/13/11</p> <p>B. was discharged at 3:32 PM on 5/14/11 to an acute psych hospital</p> <p>C. lacked any documentation in the medical record that nutritional services were provided</p> <p>2. at 2:20 PM on 9/14/11, interview with staff member ND indicated:</p> <p>a. the ED has frozen dinners that can be heated for patients as well as sandwiches, fruit, crackers, cheese, juices and milk all available in the ED for hungry patients</p> <p>b. this staff member has given food/snacks to patients and not documented this in the medical record, thus it is assumed that other staff may not always be documenting that patients have been offered/given food</p> <p>c. it cannot be proven that pts. N1, N4, and N5 received nutritional services since documentation related to this service is lacking in the medical records</p> <p>d. there is no facility policy related to nutrition in the ED, once a need is recognized, an order is received from the practitioner and dietary is contacted for a tray (or food available in the ED is provided)</p>				

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S1510	<p>410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on policy and procedure review, medical record review and interview, the facility failed to establish and implement a policy and procedure related to expectations of the contracted psychiatric agency in providing evaluations, documentation, and placement of behavioral health patients and failed to ensure that the contracted psychiatric evaluation and discharge/transfer of patients requiring inpatient psychiatric admission was accomplished in a timely manner, for 5 of 5 patients seen in the ED (emergency department). (pts. N1 through N5)</p> <p>Findings:</p> <p>1. at 1:30 PM on 9/14/11, review of the policy and procedure "Care of the Psychiatric Patient in the Emergency Department", file No.: EDS-67-P, indicated:</p>	S1510	Exclusion criteria has been revised to allow more admissions to the inpatient psych unit and expedite throughput. Patients who are awaiting placment or who are not medically stable for psych evaluation are under the continued care of the Emergency Department Medical and Nursing Staffs. A psychiatrist is on call for psychiatric emergencies. The Administrative Director of Critical Patient Services is responsible for implementation, monitoring and corrective action.	10/01/2011	

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	<p>a. under "Purpose", it reads: "To define the behavioral health assessment and management of patients displaying behavioral sequelae. To define guidelines for protecting these patients from causing harm to themselves and/or others..."</p> <p>b. under "Policy", it reads: "Patients displaying behavioral sequelae such as depression, agitation, aggression, hallucinations, suicidal thoughts or anxiety will be assessed and managed in order to determine the appropriate means for ensuring the patient's and staff's safety."</p> <p>c. under "Procedure", it reads in item #23. and 24., "Meridian Services will be notified of the patient's presence in the ED for evaluation. 24. Re-evaluation of suicide risk by Meridian Services will be performed every 12 hours."</p> <p>2. review of medical records on 9/14/11 indicated:</p> <p>a. pts N1 through N5 were seen between 5/5/11 and 5/13/11 for depression and/or suicidal ideation</p> <p>b. pt. N1 was a 16 year old who arrived with complaint of an ankle injury but was determined by ED nursing staff to have depression and suicidal thoughts--the patient also:</p> <p>A. arrived at 4:42 PM on 5/12/11 and was seen by contracted case management at 7 PM for a psych evaluation; a re-evaluation was performed at 8:49 AM on 5/13/11</p> <p>B. was not released until 6:25 PM on 5/13/11 to an adolescent psych facility</p> <p>C. lacked documentation in the medical record as to why the patient was kept overnight in the ED instead of obtaining an admission to a facility in a timely manner</p> <p>D. lacked documentation on 5/13/11 as to why transfer to an adolescent psych facility did not occur until 6:25 PM</p> <p>E. lacked documentation relating to discussion</p>				

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	<p>with family/parents related to: 1. logistics of facilities and 2. facilities accepted within the family insurance PPO (preferred provider organization) plan</p> <p>c. pt. N2 was a 28 year old with suicidal ideations who:                      A. was seen in the ED by nursing staff at 10:04 AM on 5/5/11                      B. was seen by contracted case management for a psych evaluation at 3:05 PM                      C. lacked documentation in the medical record as to the 5 hour delay in evaluation for assessment and placement to an inpatient psych facility</p> <p>d. pt. N3 was a 12 year old with depression and suicidal ideations who:                      A. was seen by nursing staff in the ED at 8:28 PM on 5/7/11                      B. was evaluated at 1:30 AM on 5/8/11 by the contracted case management staff                      C. was discharged at 4:03 AM to the adolescent psych unit/facility the patient had been discharged to home from at 3 PM on 5/7/11                      D. lacked documentation in the medical record relating to the delay in evaluation by case management from 8:28 PM on 5/7/11 to 1:30 AM on 5/8/11</p> <p>e. pt. N4 was a 45 year old manic patient with suicidal ideations who:                      A. presented to the ED at 10:30 PM on 5/8/11                      B. was advised at 1:20 AM on 5/9/11, by ED staff, that they "will have to wait until am for [case management staff] eval..."                      C. was evaluated at 10:01 AM on 5/9/11 and discharged at 3:28 PM to an acute psych hospital                      D. lacked documentation in the medical record why there was a delay in discharge from 10:01 AM to 3:28 PM after the evaluation was</p>			

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	<p>completed</p> <p>f. pt. N5 was a 21 year old with suicidal and homicidal ideations seen in the ED on 5/13/11 at 7 PM by nursing staff who:</p> <p>A. was seen for a psych evaluation at 12:50 PM on 5/14/11 by the contracted case management staff</p> <p>B. lacked documentation in the medical record as to why there was a delay in evaluating the patient until 12:50 PM on 5/14/11 when behavioral health staff was to have been present in the ED at 8 AM</p> <p>2. at 2:20 PM on 9/14/11, interview with staff member ND indicated:</p> <p>a. the contracted behavioral health case management staff are not available to assess and begin placing patients between 11 PM and 8 AM so that patients in the ED must remain overnight for an assessment and placement</p> <p>b. if the urine and lab tests aren't complete by 10:30 PM, the contracted case management staff also will not see an ED patient (needing a psych eval) until the next day (if the patient's labs/urine results are back by 10:30 PM, the case management staff may stay over to complete an evaluation, but rarely is placement done until the next day)</p> <p>3. at 3:30 PM on 9/14/11, interview with staff member NF indicated:</p> <p>a. case management is available 24 x 7 on the weekends (Friday and Saturday nights) to perform psych evals, but are not available for a "face to face" evaluation on week nights between 12 midnight and 8 AM "to be able to sleep" and "be ready to function the next day"</p> <p>b. during the night shift, a practitioner can make a call to the on-call psychiatrist (for a "physician to</p>						

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	<p>physician" conference) for immediate admission to the adult psych unit or the gero-psych unit located within this facility</p> <p>c. usually, other psych facilities do not accept admissions during the night shift, so that our staff do not need to be present in the ED then, either</p> <p>4. interview with staff members NE and NG at 3:30 PM indicated:</p> <p>a. the facility is housing patients in the ED overnight and utilizing nursing staff for the monitoring of patients every 30 to 60 minutes while waiting on psych evaluations to be performed by the contracted behavioral health group the following day</p> <p>b. medical care for patients N1 through N5 was no longer necessary/required while being housed and waiting on evaluations and placement</p> <p>c. discharge for patients N1 through N5 was not timely</p> <p>d. documentation was lacking in the medical records for pts. N1 through N5 related to reasons for delay in evaluation (other than those with overnight stays) and delays in placement</p> <p>e. the ED policies related to the care of behavioral patients do not address the expectations of a response time for the contracted psych services once contacted for an evaluation</p> <p>f. the contract between the facility and the contracted agency was not available to determine if there is a stated expectation, with time frames, related to the response by the contracted psych agency</p>				