

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD NEW ALBANY, IN 47150
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S 0000 Bldg. 00	<p>This visit was for investigation of a State complaint.</p> <p>Complaint #IN00194067 Substantiated: A State deficiency related to the allegations is cited.</p> <p>Survey date: 3/1/16</p> <p>Facility #: 006205</p> <p>QA: cjl 03/10/16</p> <p>IDR Committee held on 05-12-16, Tag S0912 modified. JL</p>	S 0000		
S 0912 Bldg. 00	<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>			

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>(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 document review, interview and observation, the nurse executive failed to ensure patient care was provided by nursing as indicated in established policies and procedures and standards of nursing care for Staffing, Bathroom Privileges, Showers and Falls Prevention for 4 of 10 patients (P1, P2, P4, and P5).</p> <p>Findings:</p> <p>1. Review of policies and procedures (P&P) indicated the following: a. The P&P titled Charge Nurses indicated: Designated RNs (registered</p>	S 0912	Complaint #IN00194067Tag: S9121. The deficiency was corrected by educating nursing staff via email that sent on May 3, 2016. Education regarding standards of nursing care for bathroom privileges, showers, falls prevention, assessing a patient after a fall and documenting the assessment in the medical record was also reiterated during nursing unit meetings on May 16, 2016 and May 18, 2016.2. Nursing management will prevent the deficiency from reoccurring by reviewing the medical record for documentation of standard	05/26/2016

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	<p>nurses) will be granted the authority to oversee the full function of a specific patient care unit, which includes promoting team work, delegation and evaluation of nursing care delivered... 5. Offer assistance/guidance to staff/MD (medical doctor) as needed by monitoring patient/staff needs. Adjust next shift staffing according to Hospital Staffing plan (To assure adequate, but cost-effective staffing). The policy was reviewed 2/16/16.</p> <p>b. The P&P titled Bathroom Privileges indicated: A patient's request for assistance overrides the bathroom privilege status and staff is expected to assist the patient with the toileting activity. The policy was reviewed 2/16/16.</p> <p>c. The P&P titled Vivid Board indicated: A dry erase board, called a "Vivid Board", is provided for each patient to record information related to the patient's current plan of care, precautions and level of activity. Therapy staff will complete the following after the initial assessment.</p> <p>i. Grooming. It is the responsibility of each assigned caregiver, as well as those assisting with care, to review the Vivid Board prior to providing therapy/care. The policy was reviewed 2/16/16.</p> <p>d. The P&P titled Falls Prevention Program indicated: Performed By: All Nursing Staff 10. If a patient experiences</p>		<p>nursing care for bathroom privileges, showers, falls prevention and assessment after a fall.3. Nursing management is responsible for the education and monitoring.4. Deficiency was corrected on May 18, 2016. 1. The deficiency regarding staffing was corrected by requiring the charge nurse to take a patient assignment in a period of staffing needs. Charge nurses were informed on May 26, 2016.2. The issue will not reoccur in the future because a charge nurse or nurse manager is available to take a patient assignment in a period of staffing needs.3. The Director of Nursing is responsible for this process.4. This deficiency was correct on May 26, 2016.</p>				

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	<p>a fall: The patient will be assessed for injury. The policy was reviewed 2/16/16.</p> <p>2. Review of the document titled West Staffing Grid indicated the following patient care staff ratio per shift for the indicated patient census:</p> <p>a. 1st Shift: Census 21; RN (registered nurse) 2, LPN (licensed practical nurse) 1, Aide 3, Support Aide 1.</p> <p>b. 1st Shift: Census 22 to 25; RN 2, LPN 2, Aide 3, Support Aide 1</p> <p>c. 2nd Shift: Census 21; RN 2, LPN 1, Aide 3, Admit Nurse 2, Support Aide 0.5</p> <p>d. 2nd Shift: Census 22 to 24; RN 3, LPN 1, Aide 3, Admit Nurse 2, Support Aide 0.5</p> <p>e. 2nd Shift: Census 25; RN 3, LPN 1.5, Aide 3, Admit Nurse 2, Support Aide 0.5</p> <p>f. 3rd Shift: Census 21 to 24; RN 1, LPN 1, Aide 2</p> <p>g. 3rd Shift: Census 25, RN 2, LPN 1, Aide 2</p> <p>3. Review of documents titled Daily Assignment Sheet(s) indicated census as noted with the number of patient care staff assigned per position on dates/shifts indicated (first half/second half designation indicates split shift:</p> <p>a. On 2/8/16 West Census 22, Shift 7-3 (1st shift): 1 Charge nurse, not assigned to patients; RNs 4; LPNs 0; Aides 2;</p>			

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	<p>Support Aide 1; Admit Nurse/second half of shift 1. Census 22-23 Shift 3-11 (2nd shift): 1 Charge nurse, not assigned to patients; RNs 1st half 3 and 2nd half 3; LPNs 1 full shift; Aides 2 first half and 3 second half; Admit Nurse 1; Support Aide 0.</p> <p>b. On 2/20/16 West Census Census 25 Shift 3-11: 1 Charge nurse, assigned to assist as CNA (certified nurses aide), see following; RNs 1st half 1 and 2nd half 2; LPNs 3 first half and 2 second half; Aides 3 first half and 3 second half (charge nurse and LPN documented as aides); Admit Nurse 1; Support Aide 1. Census 25 Shift 11-7: 1 Charge nurse, not assigned to patients; RNs 2; LPNs 0; Aides 2.</p> <p>4. Review of medical records (MR) indicated the following:</p> <p>a. The MR of patient P1 indicated the patient was admitted 2/5/16 with a diagnosis of R ICH (right intracerebral hemorrhage) and was an inpatient of the facility at time of survey. The MR indicated the patient experienced an in hospital occurrence on 2/8/16. MR Occurrence documentation dated 2/8/16 at 9:00am indicated the following: Patient had a fall, states he/she was reaching for the call light. Prior to fall patient was left in room with all safety precautions in place...patient asked nurse</p>			

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	<p>if he/she could go back to bed, patient informed he/she had therapy in 15 minutes and should stay up in the wheel chair... Nurses Note Summary Response to Treatment documentation dated 2/8/16 06:26hrs, electronically signed by N1, indicated pt had a fall today. Nurses Note Summary Nursing Notes documentation indicated the following: On 2/8/16 08:30hrs Safety, Falls Risk Assessment; Impulsiveness...Falls during hospital admission 15pts...: 1 Known falls within 30 days of current admission. 09:00hrs Safety, Occurrence, Comments: Patient had a fall... 20:45hrs Discharge Information, Transfer to/return from acute care: Patient returned from Hospital 2...Assessment upon return Ax3 (alert x 3), no skin issues...The MR/Nursing Notes lacked documentation of patient assessment for injury post fall.</p> <p>b. The MR of patient P2 indicated the patient was admitted 2/13/16 with a diagnosis of CVA (cerebral vascular accident) left hemiparesis and was a current inpatient of the hospital. The MR Information sheet indicated Activity/Limitations: May shower. CNA Bathing documentation lacked documentation of a shower/bath provided on 02-15-16 & 02-20-16. Nursing Notes Interventions list and Plan of Care included the following as automatic frequency: CNA Grooming/Hygiene</p>			

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	<p>Daily (8am, 8pm), CNA Bathing Daily (8pm), CNA Elimination Daily (2pm, 10pm, 6am), CNA Toileting/Toilet transfer Daily (2pm, 10pm, 6am). CNA Toileting/Toilet transfer lacked documentation of Toileting/Toilet between 2/20/16 09:00hrs and 2/21/16 00:25hrs.</p> <p>c. The MR of patient P4 indicated the patient was admitted 2/18/16 with a diagnosis of CVA (cerebral vascular accident) left hemiparesis and was a current inpatient of the hospital. The MR indicated the patient experienced an Occurrence 2/20/16 at 20:30hrs. Occurrence documentation 2/20/16 8:30pm indicated the following: Transferring per sliding board from W/C (wheelchair) to bed with 3 assist. Patient very tired. Began sliding from side of bed eased to the floor per 2 nurses. Family at bedside. Assisted back to bed from floor using Hoyer pad to lift. Assist of 4. Nursing Notes 2/20/16 20:20hrs Safety--Occurrence Comments indicated the same information as the Occurrence. The MR/Nursing Notes lacked documentation of assessment for injury.</p> <p>d. The MR of patient P5 indicated the patient was admitted 1/27/16 with a diagnosis of CHF (congestive heart failure) and was discharged 2/11/16. The MR Information sheet/Nursing Assistant Worksheet Interventions indicated CNA</p>			

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	<p>Toileting/Toilet transfer, Daily (2pm, 10pm, 6am). CNA Toileting/Toilet transfer lacked documentation of Toileting/Toilet between 2/1/16 08:40hrs and 2/2/16 00:41hrs.</p> <p>5. On 3/1/16 at 3:35pm, P1, in the presence of PS1, indicated that on at least one occasion, he/she was taken to breakfast without first being taken to or offered bathroom (BR) assistance. On one occasion, upon return to room, in wheelchair (W/C), he/she requested bathroom assistance (from N1) and was told there was not time before therapy. P1 indicated he/she, in the W/C, was positioned at the foot of the bed facing the window with his/her left side toward the foot of the bed and the call light placed on the bed near the foot end. P1 indicated he/she could not wait until therapy time for BR assistance and reached for the call light across the body with his/her good hand (right), indicating flaccidity (very limited use) of the left, and in doing so, the W/C tipped to the left and fell to the ground resulting in P1 hitting his/her head. P1 indicated he/she was shortly thereafter taken to therapy. PS1 indicated he/she questioned P1s participation in therapy so soon after a fall and hit to the head and was told the patient would be fine. PS1 and P1 indicated upon second attempt for the</p>			

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	<p>patient to stand he/she began vomiting, experienced loss of bowel continence and was later transferred to an acute hospital for a CT (computed topography) scan, then to another hospital for comparison and later returned to this facility/hospital. Neither P1 nor PS1 indicated staff evaluation/assessment of injury prior to patient vomiting.</p> <p>6. On 3/1/16 at 10:15am, patient P2 indicated the following: Staff, when asked for help/assistance, will not help right away. States not offered bathroom assistance before breakfast (BF) and feels is not given time for personal needs. States has had only 1-2 showers in 2 weeks since admission and is allowed to have showers. P2 indicated staff is not offering hygiene and indicated he/she has heard staff (CNA staff) tell nursing staff that the patient was offered and that he/she has refused showers/hygiene/baths. P2 stated he/she has not refused and indicated would very much like to shower. P2 indicated that on the dry erase board on the wall, it was indicated that he/she should/could have a shower every other day. P2 indicated he/she had not reported or complained of not having showers as indicated except to a family member and possibly physician. The dry erase board on the wall of the patient's room was observed, during</p>			

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	<p>interview, to have documentation indicating the patient may shower every other day, 3 days per week.</p> <p>7. On 3/1/16 at 10:25am, patient P4, in the presence of PF4, indicated getting assistance for BR may sometimes take longer than would like. PF4 indicated the patient had been dropped 2 times since admission, but did not readily recall the dates. PF4 states an aide once came to assist with toileting and when questioned about needing more assistance due to P4's size and condition, the aide informed PF4 that no other staff was available. PF4 indicated one fall occurred by an aide attempting to assist out of the W/C in which PF4 was able to assist P4 to fall onto the bed and the 2nd was a fall with the attempted use of a transfer board after failure of a Hoyer lift. P4 and PF4 indicated they did not feel the patient was injured in either occurrence, but did not indicate knowledge of an injury assessment.</p> <p>8. On 3/2/16 at 1:05pm, A2, Director of Nursing, indicated the charge nurse is not typically assigned patient care or included in the staffing grid count, but will assist with patient care if needed and if do so are written in on the Daily Assignment Sheets where/when they assisted.</p>			

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