

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150035	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2012
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NAME OF PROVIDER OR SUPPLIER PORTER REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST US HWY 6 VALPARAISO, IN 46383
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S0000	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00105487</p> <p>Substantiated: Deficiency cited related to the complaint</p> <p>Date: 8/28/12 and 8/29/12</p> <p>Facility Number: 005033</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 10/29/12</p>	S0000		

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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S0912	<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>The chief nurse executive failed to ensure the implementation of the fall policy for 1 of 4 patients (pt. #2).</p> <p>Findings:</p>	S0912	Plan of Correction:1. Policy and Procedure reviewed and updated2. All Nursing staff and Therapy Rehab staff were re-educated on fall risk assessment and need to	12/17/2012			

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	<p>1. at 1:50 PM on 8/28/12, review of the policy and procedure "Fall/Restraint Prevention Program" with a policy number of 6010-01-19 and a last reviewed date of June 2010, indicated:</p> <p>a. under section 6. "High Risk Interventions include the Standard Risk Interventions and:..."E. The patient will be assisted to the bathroom by staff and the staff will remain with the patient..."</p> <p>2. Review of patient medical records during the survey process of 8/28/12 and 8/29/12 indicated:</p> <p>a. pt. #2 had a fall on 2/16/12 at 8:45 AM while sitting on a bedside commode in the bathroom when therapy staff stepped away to retrieve supplies from the patient's hospital room</p> <p>3. interview with staff member NA at 1:45 PM on 8/28/12, 10:25 AM and 3:20 PM on 8/29/12, indicated:</p> <p>a. the purpose of rehab is to promote patients' independence and self care</p> <p>b. it is difficult, when the patient wishes dignity and privacy, to force the patient to allow staff in the bathroom with them during toileting</p> <p>c. pt. #2 had been doing personal care in the bathroom under the supervision of therapy staff prior to the fall of 2/16/12 and was able to perform these duties without aid, so it was thought that leaving</p>		<p>reassess and update to reflect condition of patient. The portion of the policy regarding staying with the patient when using the rest rom was reinforced and discussed. Education completed by Department Director on 12/13/123. The Department Director rounded to monitor compliance during the week of 12/17/12 and verified 100% compliance. 4. Maintaining compliance will be ensured by adding a daily safety huddle for the unit and reviewing any fall data and compliance with standards. This was implemented 12/17/124. The Department Director was responsible for completion of the above noted plan that was completed on 12/17/12.</p>				

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	<p>the patient briefly to enter the patient's hospital room for supplies would not be an issue</p> <p>d. this staff member felt the fall policy was being followed when it reads: "the patient will be assisted to the bathroom by staff and the staff will remain with the patient", as the staff remaining within the patient room, not specifically in the restroom</p> <p>4. at 3:15 PM on 8/29/12, interview with staff member NC indicated:</p> <p>a. the fall policy was interpreted by this staff person in that: staff should be "within arm's length" of a patient who is at fall risk while they are assisting that patient in ambulating, toileting, or any other activity while the patient is out of bed</p>			

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S0930	<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. The registered nurse failed to ensure that patient comfort and health was monitored related to bowel processes for four of four patients. (pts. #1, #2, #3 and #4)</p> <p>Findings: 1. Review of patient medical records during the survey process of 8/28/12 and 8/29/12 indicated: a. Patient #1 had a period between 2/12 and 2/16/12 without documentation of a BM (4 days) and two periods of 3 days without documentation (1/31/to 2/3/12 and 2/7 to 2/10/12). b. Patient #2 had a period of 7 days, from 2/1/12 to 2/8/12, in which no BM was noted on either form and two 3 day periods from 2/11 to 2/14/12 and 2/22 to 2/25/12. c. Patient #3 had a 5 day period of no BM documentation from 5/15 to 5/20/12 and two 3 day time frames from 5/4 to 5/7/12 and 5/22 to 5/25/12. d. Pt. #4 only had one BM documented on 6/21/12 on the I & O form (admission was on 6/6/12).</p>	S0930	<p>Plan of Correction:1. Bowel Management Policy reviewed and updated.2. Nursing Staff educated by Unit Director on 12/13/12 with emphasis on the requirement to document atghe assessment intervals and ongoing monitoring of daily activity.3. Bowel Status will be included on agenda to review status during the weekly team conferences and the record will be checked at that time to verify documentation is present. 4. The Department Director added a monthly indicator to monitor compliance with bowel activity to the schedule for 2013. This monitoring is reported to the hospital Quality Management Committee and the Board of Trustees quarterly.Person Responsible for Corrective Action: Department DirectorOngoing Compliance : Inclusion of ongoing monitor in Department PI plan</p>	12/17/2012			

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	<p>2. interview with staff member NA at 1:45 PM on 8/28/12, 10:25 AM and 3:20 PM on 8/29/12, indicated:</p> <p>a. there is no policy/procedure related to how long to let a patient go without a bowel movement, or related to the monitoring of patient bowel processes- -this is patient specific and may be based on medications, such as: pain meds (which are known to cause constipation)</p>			