

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150021	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/03/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845
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S 0000 Bldg. 00	<p>This visit was for the investigation of two State hospital complaints.</p> <p>Complaint Numbers: IN00165265 Substantiated, State deficiencies related to the allegations are cited.</p> <p>IN00172412 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 9/3/15</p> <p>Facility Number: 005020</p> <p>QA: cjl 09/23/15</p> <p>IDR Committee met on 11-12-15. Tag S0420 deleted. JL</p>	S 0000		
S 0930 Bldg. 00	<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</p>	S 0930	Tag S 0930 – 410 IAC15-1.5-6	09/04/2015

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>interview, the nursing executive failed to ensure the implementation of the fall prevention policy for 2 of 3 geri psych patients, (Pts. #1 and #2); and failed to implement the nursing assessment policy for 1 of 3 geri psych patients, (Pt. #2).</p> <p>Findings:</p> <p>1. Review of the policy "Fall Prevention - Adult and Pediatrics", no policy number, last approved on 10/2013, indicated:</p> <p>a. Under section "III. Procedure - Admitted Patients:", it reads: "A. Assess adult patients for fall risk: 1. On admission. 2. Twice daily (suggested 0900 and 2100). 3. When a change in condition occurs. 4. Following a fall occurrence...".</p> <p>b. Under section "VIII Addendum(s)", it reads: "A. Parkview Behavioral ADDENDUM G: PBH (Parkview Behavioral Health) HOSPITAL A. Communication of High Risk for Falls 1. Bridgeway Unit (geri psych) follows Parkview Behavioral Health policy for assessment and reassessment...3. If a patient is at all moderate/high fall risk upon assessment then, Parkview Health Fall Policy will be implemented."</p> <p>2. Review of geri psych patient medical records indicated:</p> <p>a. Pt. #1 was an 89 year old admitted to</p>		<p>Nursing Service (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient</p> <p>Findings: This RULE is not evidenced by: Based on document review and interview, the nursing executive failed to ensure the implementation of the fall prevention policy for 2 of 3 geri psych patients, and failed to implement the nursing assessment policy for 1 of 3 patients. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction The deficiency was corrected effective, February 2015. Staff were educated and received additional training on appropriate charting and the fall policy. Additionally, on 7/24/2015 a mandatory unit meeting for all staff was held where further education on admission charting, documentation and the fall policy was provided. On 9/3/2015 as well as 9/29/2015 (16) audits were completed on all current inpatient charts on Bridgeways, our geri psych unit. The charts were audited for admissions assessments and fall protocol compliance. The audit revealed a 99% compliance rate in both areas. 2. How are you going to prevent the deficiency from recurring in the future Education of staff will continue to</p>				

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	<p>the geri psych unit on 9/12/14. The patient was documented as having fallen on 9/21/14 after removing their tray from the "safety chair" and getting up without assistance. Per nursing documentation:</p> <p>A. The patient fell at "approximately 11:13 AM". The first "Morse Fall Risk" assessment after the fall was at 1:06 PM.</p> <p>B. Morse Fall Risk assessments were greater than every 12 hours with documentation as follows:</p> <p>I. From 7 PM on 9/14/14 to 1:16 PM on 9/15/14.</p> <p>II. From 11:45 PM on 9/20/14 to 1:06 PM on 9/21/14.</p> <p>III. From 2:33 AM on 9/25/14 to 7:08 PM on 9/25/14.</p> <p>IV. From 7:08 PM on 9/25/14 to 1:20 PM on 9/26/14.</p> <p>V. From 1:51 PM on 9/30/14 to 3:45 AM on 10/1/14.</p> <p>VI. From 12:21 PM on 10/2/14 to 3:00 AM on 10/3/14.</p> <p>b. Pt. #2 was a 69 year old admitted to the geri psych unit on 9/25/14 at 12:46 AM, with the first fall risk assessment performed at 10:28 AM that day.</p> <p>3. At 12:15 PM on 9/3/15, interview with the director of behavioral health services, staff member #52, indicated:</p> <p>a. The behavioral unit follows the hospital fall prevention policy.</p>		<p>occur monthly to ensure that staff know and understand the fall prevention policy, nursing assessment requirements and the fall protocol. Random audits will be completed monthly to ensure that the staff are compliant in both areas. 3. Who is going to be responsible for the numbers 1 and 2 above, i.e. director, supervisor, etc.? The unit manager will be responsible for education and compliance. 4. By what date are you going to have the deficiency corrected The deficiency has already been corrected and will continue to be monitored monthly on an ongoing basis until 100% compliance is reached and maintained for 3 months.</p>	

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	<p>b. It was agreed that the fall risk assessment for pt. #2 was not done upon admission, as expected, and per policy.</p> <p>c. It was agreed that the policy was not followed for pt. #1, as stated in 2. a. above.</p> <p>4. Interview with staff member #50, a quality and risk specialist, at 2:20 PM on 9/3/15, indicated;</p> <p>a. The behavioral unit follows the hospital fall prevention policy.</p> <p>b. It is expected that fall risk assessments, per the Morse Fall Risk scale, will be done every 12 hours, even though this is not clear, or specifically stated, in the Fall Prevention policy.</p> <p>c. It was agreed that the policy was not followed for pt. #1, as stated in 2. a. above.</p> <p>5. Review of the policy "Nursing Assessment and reassessment (sic): Admitted Patients", no policy number, last approved 12/2013, indicated under "V. Procedure"...3. The admission assessment will be initiated upon admission to the unit and will be completed within eight hours or sooner as defined by the unit's standard of care...".</p> <p>6. Pt. #2 was admitted to the geri psych unit at 12:46 AM on 9/25/14 and, per nursing documentation, did not have a</p>			

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	nursing assessment begun until 10:00 AM on 9/25/14. 7. At 12:15 PM on 9/3/15, interview with the director of behavioral health services, staff member #52, indicated: a. It was unknown why nursing staff failed to begin a nursing assessment for pt. #2 so long after admission. b. There should have had some type of documentation in the 9.25 hours of delay. c. There was only a 2:16 AM temperature noted by mental health tech staff for this patient during the 9.25 hours after admission to the unit.			