

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150173	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2016
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 5165 MCCARTY LN LAFAYETTE, IN 47905
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S 0000 Bldg. 00	The visit was for investigation of a State complaint. Complaint Number: IN00175901 Unsubstantiated: Lack of sufficient evidence. Deficiencies unrelated to the allegations are cited. Date: 2-10-16 Facility Number: 011506 QA: cjl 04/18/16	S 0000	In receipt of survey deficiencies on May 2, 2016, nearly 3 months after visit I see no mention of due date for POCs Will attempt to complete within 7-10 business days	
S 0744 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review, the facility failed to follow its policy/procedures and ensure all medical record entries were complete for 3 of 6 medical records (MR) reviewed (patient #s 1, 4 and 6). Findings include: 1. The policy/procedure Content of Medical Records (effective 9-11)	S 0744	Policy AMDCL 5.00 previously indicated a copy of the information faxed to Court also be provided to the patient / surrogate. This does not occur in practice and upon conversation with social work, is not required by Indiana Code. The Policy has been updated to reflect current practice. (see attached). No additional education needed as policy changes reflect actual / current practice. Officers require	06/01/2016

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>indicated the following: "The following applies to all entries in the medical record: All entries must be legible and complete..."</p> <p>2. The policy/procedure Emergency Detention Order (effective 8-13) indicated the following: "Patients who are admitted involuntarily and/or a surrogate must be given the following information: Copies of all paperwork that is faxed to the Court regarding the detention. All relevant information including but not limited to the topics listed below will be documented in the patient's record... (d) Information given to the patient or family member (e) Paperwork given to the patient/surrogate."</p> <p>3. The MR on 6-14-15 for patient #1 failed to indicate the patient or surrogate was provided with copies of the Emergency Detention Order (EDO) paperwork.</p> <p>4. The document Safe Keeping Property Form dated 6-14-15 at 1640 hours for patient #1 indicated the personal property including a purse x1 and prescription medication x2 were received by the ED nurse N11 and Officer #509 and #507 and no documentation indicated the personal property was released to the</p>		<p>paperwork in hand prior to performing an EDO transport, thus adherence is ongoing. Completed by Norma Gilbert, Director Clinical Excellence. Review of the patient in question found Valuables were handled in accordance with Security Policy: Safekeeping Policy SS 6.03(see attached). Per policy, <i>continuous</i> monitoring of the process is completed via Security maintenance of a log. Completed by Jon Laird, Manager Security Per Policy: Patient Transfer from IUH Arnett Emergency Department ED 1.15, Section C, item 3; only copies of relevant portions of the medical record not available electronically shall be sent. Lack of documentation on the Transfer Summary& Certification form may be reflective of transfers within IUH, where electronic health record (EHR)s are shared. Transfer Summary Audit from May 11 - May 24: 12/13 with appropriate documentation and / or transferred within IU Health. ED Manager will be provided feedback and continue to perform random audits as part of ongoing improvement initiative. ED staff will be encouraged to complete the form in its entirety and indicate on the Transfer and Summary Certification form when information is available via the EHR (Cerner). <u>Education</u> will be provided to all staff at daily ED Huddlesfor 30 days, beginning</p>		

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S 0912 Bldg. 00	<p>patient or surrogate.</p> <p>5. In interview on 2-10-16 at 1425 hours, the director of quality, staff A1, confirmed that the MR for patient #1 lacked the indicated documentation.</p> <p>6. The policy/procedure Patient Transfer from IU Health Arnett Emergency Department (effective 8-14) indicated the following: "Transferring facility is responsible for sending copies of relevant portions of the medical record that are not available in the electronic medical record (EMR) to the receiving facility."</p> <p>7. Review of the document Transfer Summary and Certification for patient #4 and patient #6 lacked documentation indicating any copies of the MR were sent with the patient to the receiving facility.</p> <p>8. In interview on 2-10-16 at 1615 hours, the director of quality, staff A1, confirmed that the MR for patient #4 and patient #6 lacked the indicated documentation.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p>		<p>June 1st, 2016. <u>Monthly audits</u> of ED transfers to outsidefacilities to ensure Transfer Summary and Certification forms are complete. Responsible Party: Jamie Jackson, ED Manager</p>		

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	<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>Based upon document review and interview, the nurse executive failed to ensure that the policy/procedure Patient Harm and Event Reporting was followed for 1 of 6 medical records (MR) reviewed (patient #1).</p> <p>Findings include:</p>	S 0912	Per Policy: Patient Harm and Event Reporting ADM 2.03, the elopement of the patient from the ED was recorded as an event by Security (Section V, Item E.) The alleged foot /ankle injury within the ED was not recorded as an event report. According to policy, patient injury or harm (the foot injury) and the elopement from	05/10/2016

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	<p>1. The policy/procedure Patient Harm and Event Reporting (approved 11-13) indicated the following: "Examples of events include... unexpected clinical events or adverse outcomes... behavior events... falls, accidents or injuries... missing patients (AMA, elopement, etc.)... Arnett Safety and Security Department maintains a companion security event reporting software for... other events with security involvement... as soon as possible after recognition of the event, individuals who witness, discover, or believe an event has occurred should complete an event report... appropriate leadership/individuals receive early notification of event reports via the following... brief review of event reports at the Daily Awareness and Safety Huddle (DASH)..."</p> <p>2. The MR for patient #1 indicated the patient experienced an emotional outburst in the ED on 6-14-15, including the following: jumping up and down, pulling out the intravenous (IV) access, removing the electrocardiogram leads, and shouting demands for a cigarette and coffee. While jumping up and down, the patient collapsed and began rolling on the ground and complained of right foot pain. The MR entry at 1615 hours by physician MD11 indicated the patient was notified</p>		<p>the ED both warranted reporting as unexpected events or adverse outcomes. <u>Education</u> will be provided to all staff at daily ED Huddles for 30 days, beginning June 1st, 2016. Ongoing monitoring will be performed by ED Manager / Director as they receive and review events occurring in the ED. Responsible Person: Jamie Jackson, ED Manager</p>	

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	<p>by the physician that they (patient #1) would be transferred to an inpatient psychiatric facility after an Emergency Detention Order (EDO) was obtained. The MR entry at 1650 hours by physician MD11 indicated the discovery that patient #1 was no longer in the room, the security department was contacted to search for the patient, and no staff was aware of the patient's location/destination. The MR entry at 1700 hours by physician MD11 indicated that patient #1 was located at the food court by security staff and escorted back to the ED room A05. The MR indicated an x-ray of the patient's right foot was completed and no acute foot injury was identified.</p> <p>3. Review of 54 Incident/Event reports associated with the ED for the period from 6-01-15 to 6-30-15 failed to indicate an event involving patient #1.</p> <p>4. Review of the Security log for 6-14-15 indicated a security response at 1614 hours for a combative patient (patient #1) and indicated a security response at 1649 hours for a missing patient (patient #1).</p> <p>5. During an interview on 2-10-15 at 1400 hours, the director of quality, staff A1, confirmed the safety huddle (DASH) minutes dated 6-15-15 failed to indicate a</p>			

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S 0930 Bldg. 00	<p>review of the combative patient event or of the patient elopement event and confirmed that no other Incident/Event report was completed by an ED staff about a combative patient with a suspected foot injury or about a patient with behavioral concerns eloping from the ED after being notified about an EDO order and plan for transfer to a psychiatric facility.</p> <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 upon document review and interview, the registered nurse failed to supervise and evaluate the care provided to each Emergency Department (ED) patient for 1 of 6 medical records (MR) reviewed (patient #1).</p> <p>Findings include:</p> <p>1. The policy/procedure Suicide Precautions (effective date 8-13) indicated the following: "The ED is likely to be the most common site of</p>	S 0930	Patient in question was identified as a suicide risk,yet close monitoring as defined by the policy were not documented. Lack of adherence to the Suicide Precautions policy has been recognized by the ED staff and leadership as a significant opportunity for improvement. The unit based Professional Practice Council (PPC) has identified care of the emotionally disturbed / intoxicated patient as an area of focus and is initiating a broad initiative to improve care. The list specifically includes: · Removal of patient clothing · Searching and	06/16/2016

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	<p>patients at risk for suicide to enter the hospital services... patients at risk for suicide should never be left alone in the room or the restroom. The patient should not be left alone until discharge and/or transfer from the ED... the patient will remain in the assigned room unless accompanied by staff... when the risk for suicide is identified, continuous monitoring is immediately initiated. May be initiated without an order..."</p> <p>2. Review of the MR entry for patient #1 on 6-14-15 at 1505 hours by staff nurse N11 indicated a positive (yes) response was entered for each of the (2) suicide risk screening questions after the patient #1 stated they had attempted suicide by taking an overdose of prescription medications and smoking marijuana (and drug screen test results confirmed the presence of benzodiazepines and marijuana).</p> <p>3. Review of the initial MR entry on 6-14-15 at 1448 hours by physician MD11 indicated that patient #1 reported they had been having suicidal thoughts and indicated they (Pt#1) had a clear plan for suicide if they were released from the ED.</p> <p>4. Review of the MR entry on 6-14-15 at 1615 hours by ED physician MD11</p>		<p>securing belongings · Timed rounding · Need for 1:1 care if actively attempting harm · Consideration of continuous video surveillance The PPC has been charged by ED leadership to propose corrective actions at the June 16th, 2016 meeting. Until receipt of the Council's recommendations, <u>education</u> regarding suicide precautions will be provided to ED staff at daily ED Huddles. The referenced policy will be revised accordingly. <u>Monthly random audits</u> will be conducted to determine compliance with expectations outlined in policy ADMCL 5.04 Responsible Party: Jamie Jackson, ED Manager</p>	

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	<p>indicated that patient #1 became agitated, pulled out the intravenous (IV) access, removed the electrocardiogram leads, and began jumping up and down before collapsing on the floor with a complaint of right foot pain. The entry indicated patient #1 was re-evaluated by the physician and notified of the plan to transfer the patient to an acute inpatient psychiatric facility after an Emergency Detention Order (EDO) was obtained.</p> <p>5. The EDO application indicated the following: "Applicant believes that if the person named above is not restrained immediately the person will attempt to injury (sic) him/herself ..." and no MR documentation indicated Suicide Precautions and/or continuous monitoring was initiated or implemented for the at-risk patient.</p> <p>6. Review of the MR entry on 6-14-15 at 1650 hours by physician MD11 indicated the discovery that patient #1 was not present in the ED room A05 or elsewhere in the ED. The entry indicated no ED staff were informed or certain where the patient #1 might have gone after being informed about the plan for an EDO and transfer to a psychiatric facility and the MR failed to indicate any new safety measures including continuous monitoring was initiated or implemented</p>			

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S 1510 Bldg. 00	<p>for patient #1 after the patient was located at 1700 hours in another part of the building by hospital security staff and returned to ED room A05.</p> <p>7. During an interview on 2-10-16 at 1425 hours, the director of quality, staff A1, confirmed that the MR failed to indicate continuous monitoring or any other safety measures were implemented for patient #1.</p> <p>8. In interview on 2-10-16 at 1455 hours, the ED manager, staff A2, confirmed the MR failed to indicate that continuous monitoring or any other safety measures were implemented for patient #1 following the patient's elopement from the ED and no other documentation was available.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 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>			

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	<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 document review and interview, the medical staff failed to follow its policy/procedures and ensure the safety of psychiatric patients in the emergency department (ED) for 1 of 6 medical records (MR) reviewed (patient #1).</p> <p>Findings include:</p> <p>1. The policy/procedure Suicide Precautions (effective date 8-13) indicated the following: "The ED is likely to be the most common site of patients at risk for suicide to enter the hospital services... suicide gestures and suicidal ideation should be considered serious threats to patient safety... risk for committing suicide is a psychiatric emergency...(and)... if it is determined that the patient is at risk for committing suicide, Suicide Precautions will be ordered... the patient should not be left alone until discharge and/or transfer from the ED..."</p>	S 1510	<p>Patient in question was identified as a suicide risk,yet close monitoring as defined by the policy were not documented. Lack of adherence to the Suicide Precautions policy has been recognized by the ED staff and leadership as a significant opportunity for improvement. The unit based Professional Practice Council (PPC) has identified care of the emotionally disturbed / intoxicated patient as an area of focus and is initiating a broad initiative to improve care. The list specifically includes: · Removal of patient clothing · Searching and securing belongings · Timed rounding · Need for 1:1 care if actively attempting harm · Consideration of continuous video surveillance The PPC has been charged by ED leadership to propose corrective actions at the June 16th, 2016 meeting. Until receipt of the Council's recommendations, <u>education</u> regarding suicide precautions will be provided to ED staff at daily ED Huddles.The referenced policy will be revised accordingly. <u>Monthly,random audits</u> will be</p>	06/16/2016			

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	<p>2. Review of the MR entry for patient #1 on 6-14-15 at 1505 hours by staff nurse N11 indicated a positive (yes) response was entered for each of the (2) suicide risk screening questions after the patient #1 stated they had attempted suicide by taking an overdose of prescription medications and smoking marijuana (and drug screen test results confirmed the presence of benzodiazepines and marijuana).</p> <p>3. Review of the initial MR entry on 6-14-15 at 1448 hours by physician MD11 indicated that patient #1 reported they had been having suicidal thoughts and indicated they (Pt#1) had a clear plan for suicide if they were released from the ED.</p> <p>4. Review of the MR entry on 6-14-15 at 1615 hours by ED physician MD11 indicated that patient #1 became agitated, pulled out the intravenous (IV) access, removed the electrocardiogram leads, and began jumping up and down before collapsing on the floor with a complaint of right foot pain. The entry indicated patient #1 was re-evaluated by the physician and notified of the plan to transfer the patient to an acute inpatient psychiatric facility after an Emergency Detention Order (EDO) was obtained.</p>		<p>conducted to determine compliance with expectations outlined in policy ADMCL 5.04 Responsible Party: Jamie Jackson, ED Manager</p>	

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	<p>5. The EDO application indicated the following: "Applicant believes that if the person named above is not restrained immediately the person will attempt to injury (sic) him/herself ..." and no MR documentation indicated Suicide Precautions and/or continuous monitoring was ordered for the at-risk patient.</p> <p>6. Review of the MR entry on 6-14-15 at 1650 hours by physician MD11 indicated the discovery that patient #1 was not present in the ED room A05 or elsewhere in the ED. The MR indicated no ED staff were informed or certain where the patient #1 might have gone after being informed about the plan for an EDO and transfer to a psychiatric facility and the MR failed to indicate any new safety measures including continuous monitoring were ordered or implemented for patient #1 after the patient was located at 1700 hours in another part of the building by hospital security staff and returned to ED room A05.</p> <p>7. In interview on 2-10-16 at 1425 hours, the director of quality, staff A1, confirmed that the MR failed to indicate suicide precautions were ordered by the ED physician MD11 for patient #1.</p> <p>8. In interview on 2-10-16 at 1455 hours,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150173	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2016
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(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	
	the ED manager, staff A2, confirmed the MR failed to indicate that continuous monitoring or any other safety measures were ordered or implemented for patient #1 following the patient's elopement from the ED and no other documentation was available.				