STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150009	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTON CLARK HOSPITAL	1220 MISSOURI AVE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00425024 - State deficiency related to the allegation is cited at S0930. Date of Survey: 3/13/2024 Facility Number: 005009 QA:	S 0000	**1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** The Director of Behavioral Health will complete read and sign of event reporting policy number 12844814 by April 19th, 2024. Adding documentation to post falls assessment flowsheet “event report completed” “yes” or “no” in Electronic Medical Record (EMR). **2. How are you going to prevent the deficiency from recurring in the future?** Event report created through SIM (event reporting system) to include total of SIM events per unit (Behavioral Health). This report is reviewed for compliance monthly by Director of Behavioral Health and Risk Management. Audit created to include any post falls assessment with documentation of “No” event report entered. Director of Quality will audit non-compliance monthly and send outliers through PSQC (patient safety and quality council).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shaylon Kleehamer	Quality Director	04/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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			3. Who is going to be responsible for numbers 1 and 2 above, i.e., director, supervisor, etc.? The person responsible for ensuring and enforcing this process is the Director of Behavioral Health. **4. By what date are you going to have the deficiency corrected? Maximum correction time allowed is thirty (30) days from Notice of Noncompliance.** **April 19th, 2024**	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (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. Based on document review and interview, the facility failed to evaluate nursing care by not completing an incident report after a fall on 1 of 2 patients who fell during facility stay (P5). Findings include: 1. Facility policy, titled Patient Fall Prevention and Post-Fall Management (Doctor [Dr.] Tumble), PolicyStat ID 13315768, last revised 4/25/23, indicated under Documentation and Follow-up,	S 0930	**1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** The Director of Behavioral Health will complete read and sign of event reporting policy number 12844814 by April 19th, 2024.	04/19/2024

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	following the post-fall assessment: a Midas incident report should be completed. 2. Review of P5's medical record (MR) indicated P5 had a fall on 2/29/24. 3. Review of facility Incident Report Log lacked incident report for P5 in regard to a fall on 2/29/24. 4. In interview, on 3/13/24, at approximately 12:15 pm, A1 (Director of Quality) verified the MR of P5 indicated a fall happened on 2/29/24, and no incident report was entered in regard to the fall.		Adding documentation to post falls assessment flowsheet "event report completed" "yes" or "no" in Electronic Medical Record (EMR). **2. How are you going to prevent the deficiency from recurring in the future?** Event report created through SIM (event reporting system) to include total of SIM events per unit (Behavioral Health). This report is reviewed for compliance monthly by Director of Behavioral Health and Risk Management. Audit created to include any post falls assessment with documentation of "No" event report entered. Director of Quality will audit non-compliance monthly and send outliers through PSQC (patient safety and quality council). **3. Who is going to be responsible for numbers 1 and 2 above, i.e., director, supervisor, etc.?** The person responsible for ensuring and enforcing this process is the Director of Behavioral Health. **4. By what date are you going to have the deficiency corrected? Maximum correction time allowed is thirty (30) days from Notice of**	

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			Noncompliance. **April 19th, 2024**	