STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150064	A. BUILDING 00 B. WING	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE REGIONAL HEALTH SYSTEM	1941 VIRGINIA AVE CONNERSVILLE, IN 47331

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S 0000 Bldg. 00	This visit was for the investigation of one hospital licensure complaint. Complaint Number: IN00181846; Substantiated, a deficiency related to the allegations is cited. Date: 12/14/16 and 12/15/16 Facility Number: 005059 QA: 12/22/16 JL	S 0000		
S 0926 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(1) (b) The nursing service shall have the following: (1) Adequate numbers of licensed registered nurses, licensed practical nurses, and other ancillary personnel necessary for the provision of appropriate care to all patients, as needed, to include the immediate availability of a registered nurse. Based on document review and interview the nursing director failed to follow the facility policy regarding staffing when there are more than 4 patients on the unit and failed to ensure the safety of patients	S 0926	ISDH Plan of Correction 1. The facility administration has reviewed the policies and procedures regarding staffing and began hiring additional staff to increase the PRN pool of employees to meet the needs of	01/26/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	when at least one of the patients is ordered to be in "line of sight" for safety reasons. Findings Include: 1. Review of the policy Staffing Ratios & Acuity, no policy number, last revised/approved 8/2015 indicated the "Acute Program" was to have "additional and/or replacement staff" if the census is "above (4) patients". 2. Review of staffing for August/September 2015 indicated this 8 bed unit had: A. 3 patients on 8/24/15 with 3 admissions for 6 patients total. There were 2 staff on the evening shift, but only one on the night shift. B. The day shift of 8/25/15 started with 6 patients and only 1 RN. C. Documentation that indicated there were 5 patients to start 8/26/15 with only 1 RN on the day shift. D. Documentation on 9/6/15 that the unit had 5 patients with only 1 staff for each shift. E. Documentation on 9/7/15 that the day began with 5 patients and only 1 RN scheduled on the day shift. 3. At 9:15 AM on 12/15/16, interview with the administrator, staff member #52, confirmed that:		the unit. Special precautions protocols have also been reviewed and a new, more thorough form has been developed for advanced documentation. All leadership members have met including the medical director and reviewed the deficiency cited. The Nursing Supervisor has signed off daily on the staff assignment board to assure no shortage of staffing on any shift. In additional this deficiency has led to the development of the 2017 quality monitor that will be analyzed for the next 12 months. In Service training will be conducted on January 24 and 26, 2017 with all team members on this matter. 2. The facility reviewed (audited) charts of those with special precautions. The leadership and medical team met and reviewed/analyzed policies and procedures for special precautions and staffing as well as collaborated for creating an in service training to assure all team members are informed of proper protocols as well use of the panic button system for safety. The panic button is supposed to be on the person working the unit, not left in the desk drawer. 3. The facility reviewed the policies and procedures as noted above. The citation was discussed with all nursing staff on December 27 and 29, 2017 to assure they were informed of the situation. A review of the staffing	

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	A. Staffing, as listed in 2. above, was not per facility policy requiring 2 staff members if more than 4 patients are present. B. "Acuity levels" are also considered when staffing the unit, not just the number of patients. C. A charge nurse is available to the unit if needed by the unit nurse. 4. Review of the medical record for patient #1 indicated they slept in the hallway on a mattress four of the nights they were at the facility, August 27, 28, 29 and 30, 2015. 5. At 1:50 PM on 12/14/16, interview with a therapist/clinical supervisor, staff member #50, confirmed that: A. In the past, patients would occasionally sleep on their mattresses in the hallway to maintain "line of sight" when it was ordered by a practitioner. (The facility now has cots.) B. Hallway sleeping is for patients at "risk", such as sexually acting out, physically acting out, self harming, etc. for patient protection and closer observation. 6. At 2:00 PM on 12/14/16, interview with the administrative assistant, staff member #55, confirmed that there is no policy related to patients sleeping in the		policy and protocol for acquiring staff in times of need was reviewed as well. There is an administrator on call at all times to assist with staffing. A new special precautions form was created and implemented regarding special precautions. A formal training (in service) will occur in the upcoming weeks and the corrective actions will be monitored for the next 12 months. 4. These corrective actions will be monitored by the Nursing Supervisor on every patient with special precautions daily to ensure proper documentation and competency. Each month a report shall be sent to the Director for analysis. This data collected will be a quality monitor for the 2017 year. The nursing supervisor additionally will review the staffing assignment board daily and sign off for compliance indefinitely. Any staff shortages will covered (per policy). In addition, cross training of nursing staff throughout the hospital will occur on January 18, 2017 to increase the pool of staff that can be called in times of need.	

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	hallway. 7. At 11:25 AM on 12/15/16, interview with the acute care unit nurse, staff member #54, confirmed that: A. The only phone on the unit is behind the desk in the lounge. B. The panic button is in a drawer/under the desk top of the staff desk in the lounge. C. Both the phone and the panic button are approximately 20 feet from the door to the hallway where patient rooms are located. D. The RN cannot see into the hallway, nor see any of the 4 patient rooms from the desk in the lounge. E. Patients who are ordered to be "line of sight" cannot be seen from the lounge, especially from the desk where computer documentation occurs. 8. At 9:15 AM and 11:55 AM on 12/15/16, interview with the administrator, staff member #52, confirmed that: A. One staff person cannot keep a line of sight patient in their sight and perform 15 minute checks on other patients. B. One staff person cannot do their computer charting in the lounge and keep a line of sight patient within their sight, especially during the night shift when patients are in their rooms.			

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	C. Patient safety could be jeopardized with only 1 staff member present when a patient on the unit is ordered to be within line of sight. D. Even though there is a charge nurse available, they may be on one of the other two residential units when needed on the acute unit, it cannot be determined that the charge nurse is always available to the acute unit. E. If there is an emergency on the unit, the nurse cannot keep a line of sight patient within their sight and get to the panic button or phone to call for help.			