

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2024
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH FLOYD		STREET ADDRESS, CITY, STATE, ZIP COD 1850 STATE ST NEW ALBANY, IN 47150		
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S 0000 Bldg. 00	<p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00423019 - State deficiencies related to the allegations are cited at S0712, S0930, and S0936.</p> <p>Date of Survey: 2/28/2024</p> <p>Facility Number: 005040</p> <p>QA: 3/12/2024 & 3/13/2024</p>	S 0000		
S 0712 Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(1)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on document review, observation, and interview the facility failed to maintain an accurate medical record (MR) related to lack of accurate documentation of the type of mattress the patient was on for 1 of 5 (P5) MR reviewed.</p> <p>Findings include:</p> <p>1. MR indicated on 2/28/24 P5 was on a pressure</p>	S 0712	<p>0712 ACTION PLAN Baptist Health Floyd's goal is to: provide accurate medical record documentation for services rendered for each individual who is evaluated or treated in a timely manner and maintain medical records so they are readily accessible and permit prompt retrieval of information.</p>	05/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Christie Ledford

Accreditation Coordinator

03/22/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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>relief mattress.</p> <p>2. On 2/28/24 at approximately 3:53 pm, this writer observed P5 on a regular mattress, not in a specialty bed, and no pump attached to mattress.</p> <p>3. Interview on 2/28/24 at approximately 2:30 pm, A3 (Manager of Quality) verified documentation in the MR of P5 was inaccurate and indicated P5 was on a pressure relief mattress. The documentation should have indicated patient was on a regular mattress.</p>		<p>Upon review of Baptist Health Floyd's pressure reduction therapy's, it was determined that all of mattresses in use are pressure reduction devices. Learning opportunities were discovered regarding when specialty beds were to be utilized with the specific type of pressure injury noted, along with the types of pressure reduction devices available. Education will be provided for the types of mattresses and beds available, identification of pressure injuries along with accurate documentation of pressure reduction devices.</p> <p>The Surgical Inpatient nurses and nursing assistants will be educated on the definition of the different pressure reduction mattresses and specialty beds when a patient scores 18 or less on the Braden Scale. The education will be provided in an assigned electronic learning module for all Surgical Inpatient nurses and nursing assistants. This education will include the identification of the types of mattresses and beds, proper uses for the types of mattresses or specialty beds and documentation requirements for each of these in the electronic medical record.</p> <p>Responsible Party- Director of Inpatient Nursing Completion Date: 60%</p>	

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S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)		<p>of the Surgical inpatient nurses and nursing assistants will have completed the electronic learning module for Pressure Injury and Wound Reduction by April 11th ,2024 with 100% of the above staff completed by May 10th , 2024, excluding FMLA staff.</p> <p>Surgical Inpatient Leadership will perform 30 audits/ month, in real time, using the Pressure Injury Prevention Audit tool, for patients that score 18 or less on the Braden Scale for accurate documentation of pressure reduction mattress or bed utilized. This information will be captured in column 5 (appropriate mattress in use) and column 6 (Mattress documentation correct in EPIC) on this audit tool. These audits will continue until 95% compliance is met for 3 consecutive months. Coaching of staff, following the Just Culture Algorithm, will be followed for audits not meeting 95%. The audit results will be reported at the monthly Quality and Patient Safety Committee until compliance is met.</p> <p>Responsible party: Director of Inpatient Nursing</p>	

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	<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, observation, and interview, the facility failed to provide nursing care per policy/procedure related to lack of initiating pressure injury wound prevention/treatment interventions, including, but not limited to: turning patient every two hours, elevating heels off bed, providing a specialty mattress; and lack of reassessment after medication administration for 2 of 5 (P2 and P5) patient medical records (MRs) reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Facility policy, Protocol Guidelines for Treatment Pressure Injuries, Skin Tears and Perineal Dermatitis, policy number 1.2022, signed by Nursing Director 1/1/22, indicated for patients with a Braden score of 18 or below the following interventions would be initiated, including but not limited to: turn patient every 2 hours, elevate heels off bed, and consider ordering a specialty mattress. Facility policy, Pain Management and Narcotic usage, no policy number, last revised 7/25/23, indicated after (pain) medication is administered, follow-up of its effectiveness should be assessed and documented within 30 minutes. MR of P2 indicated an initial Braden Risk assessment score of 17 on 10/18/23. MR lacked documentation of turning patient every 2 hour turns during facility stay. MR indicated P2 	S 0930	<p>0930</p> <p>ACTION PLAN:</p> <p>Baptist Health Floyd's goal is to provide education and guidance for the supervision and evaluation of nursing care for patients scoring 18 or less utilizing the Braden scale and reassessment for those patients receiving pain medication. The policy Pain Management and Narcotic Usage will be updated to reflect the documentation requirement of response to pain medication administration within 30- 60 minutes to be in line with the procedure section of this policy. The Surgical Inpatient nurses will be educated on this policy by an electronic learning module.</p> <p>The Surgical Inpatient nurses will be educated on requirements of pain medication administration assessment and documentation, including timely documentation of response to pain medication that will include utilizing the pain scale and the response to interventions by an electronic learning module. The Surgical Inpatient nurses and nursing assistants will be educated on pressure injury and wound prevention interventions to be utilized and documented when</p>	05/10/2024

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	<p>received narcotic pain medication on the following dates and times, included but not limited to: 10/18/23 at 6:04 am, 10/19/23 at 3:59 am, 10/22/23 at 1:49 pm, and 10/23/23 at 2:46 pm. MR lacked documentation of response to pain medication within 30 minutes on dates and times listed above.</p> <p>4. MR of P5 indicated initial Braden Risk assessment score of 18 on 2/23/24, and was admitted with a sacral wound, present at time of admission. MR indicated on 2/27/24 at 8:00 pm, P5 had a Braden Risk assessment score of 16. MR lacked documentation of usage of a specialty mattress or of turning patient every 2 hour turns during facility stay. MR indicated P5 received pain medication on, included but not limited to: 2/24/24 at 5:41 pm, 2/28/24 at 4:17 am, and 2/28/24 at 11:39 am. MR lacked documentation of response to pain medication within 30 minutes on dates and times listed above.</p> <p>5. On 2/28/24 at approximately 3:53 pm, this writer observed P5 on a regular mattress, not in a specialty bed, and no pump attached to mattress. P5 was observed with heels directly on mattress.</p> <p>6. In interview on 2/28/24 at approximately 2:30 pm, A3 (Manager of Quality) verified the MR findings of P2 and P5 as described above.</p>		<p>a patient scores 18 or less utilizing the Braden scale. This education will include, but not limited to: turning a patient every two hours, elevating the heels off the bed, and consideration of providing a specialty mattress along with proper documentation. The education will be assigned to all Surgical Inpatient nurses and nursing assistants by an electronic learning module.</p> <p>RESPONSIBLE PARTY: Director of Inpatient Nursing</p> <p>COMPLETION DATE: 60% of the Surgical Inpatient nurses will have completed the education by the electronic learning module for Pain Medication Administration Education by April 11th ,2024 with 100% of staff completed by May 10th, 2024, excluding those on FMLA.</p> <p>60% of the Surgical Inpatient nurses and nursing assistants will have completed the education by the electronic learning module for Pressure Injury and Wound Prevention by April 11th ,2024 with 100% of staff completed by May 10th, 2024, excluding those on FMLA.</p> <p>A peer-to-peer audit will be conducted with the Surgical Inpatient nursing staff, utilizing the Pain Reassessment Audit tool, for patients receiving pain medication. The audit will monitor timely follow up pain assessment</p>	

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				documentation utilizing the pain scale within 30- 60 minutes of administration of pain medication and the response to the interventions. These audits will be collected by Surgical Inpatient Unit leadership. The audits will continue until 95% compliance is met for 3 consecutive months. Coaching of staff, following the Just Culture Algorithm, will be followed for audits not meeting 95%. The audit results will be reported at the monthly Quality and Patient Safety Committee until compliance is met. Surgical Inpatient Unit Leadership will perform 30 audits/ month in real time, utilizing the Pressure Injury Wound Prevention Audit tool, for patients that score 18 or less on the Braden Scale for accurate utilization and documentation of pressure injury and wound prevention interventions. This audit information would include columns 5 ,6, 7, and 8 on the audit tool. These audits will continue until 95% compliance is met for 3 consecutive months. Coaching of staff, following the Just Culture Algorithm, will be followed for audits not meeting 95%. The audit results will be reported at the monthly Quality and Patient Safety Committee until compliance is met.

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S 0936 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities.</p> <p>Based on document review and interview, the facility failed to ensure pain medication administration/reassessment competency for 2 of 4 (A4 and N4) nursing personnel files reviewed; and failed to maintain documentation of general new hire orientation for 1 of 2 (N5) Nursing Assistants personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file review of A4 (Director of Nursing [DON]) lacked evidence of competency in pain medication administration/reassessment. 2. Personnel file review of N4 (Licensed Practical Nurse) lacked evidence of competency in pain medication administration/reassessment. 3. Personnel file review of N5 (Nursing Assistant) lacked evidence of general new hire orientation. 4. Interview on 2/28/24 at approximately 4:47 pm, A8 (Human Resources [HR]) verified there is no differentiation on competency requirements for RN and LPN. 5. Interview on 2/28/24 at approximately 4:53 pm, A4 (DON) verified pain medication administration/reassessment is not covered in 	S 0936	<p>0936 ACTION PLAN: Baptist Health Floyd's goal is to demonstrate and document competency in fulfilling assigned responsibilities for nursing services.</p> <p>As of March 3rd, 2021, all new employees sign an attestation of New Employee Orientation through the electronic learning module. Prior to March 3rd, 2021, proof of attendance was tracked manually and saved to orientation and personnel files.</p> <p>Baptist Health Floyd's Human Resources Department will run a report of all current (as of March 19, 2024) Surgical Inpatient staff members to ensure all employee files contain proof of New Employee Orientation.</p> <p>Baptist Health Floyd's Human Resource will also run a report of all current (as of March 19, 2024) Surgical Inpatient direct patient care nurses to ensure the Competency Based Orientation (CBO) packets are completed and in the employee file. The</p>	04/11/2024

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	<p>new nurse orientation.</p> <p>6. Interview 2/28/24 at approximately 4:55 pm, A7 (HR Manager) verified no documentation of general orientation for N5 (NA), and no documentation of pain medication administration/reassessment education for N4 (LPN). A7 verified no evidence of pain medication administration/reassessment competency for A4 (DON).</p>		<p>Competency Based Orientation packet demonstrates competency of nursing staff during the orientation process that includes pain assessment and reassessment requirements.</p> <p>Responsible Party: Human Resources Manager</p> <p>Completion Date: April 11th, 2024</p> <p>Baptist Health Human Resources department will run an audit report of 100% of Surgical Inpatient Staff new hires each month to ensure there is evidence of new employee orientation (NEO) in each employee file within 30 days of their hire date. Compliance will be met when 100% is reached for 3 consecutive months. The audit results will be reported at Quality and Patient Safety Committee meeting monthly until compliance is met.</p> <p>Baptist Health Human Resources department will run an audit report of 100% of all newly hired direct patient care nurses to the Surgical Inpatient Unit for the Competency Based Orientation completion in the employee file within 2 weeks of completing orientation to ensure competency is demonstrated regarding Pain assessment and reassessment. Compliance will be met when 100% is reached for 3 consecutive months. The audit results will be reported at Quality and Patient Safety Committee</p>	

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			meeting monthly until compliance is met.	