STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150082	A. BUILDING 00 B. WING	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEACONESS HOSPITAL INC	600 MARY ST EVANSVILLE, IN 47710

(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 the investigation of a State Licensure Hospital complaint. Complaint Number: IN00415366 - Deficiency related to the allegation is cited. (Tag 0930) Survey Date: 10/2/24 Facility Number: 005074 QA: 11/1/24	S 0000		
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, Nursing Services failed to turn and reposition patient every 2 hours for 1 of 5 patient medical records reviewed. (P3) Findings include: 1. Facility failed to follow policy titled Patient Assessment/Reassessment Plan, Policy number P&P 40-29 S, Last Review Date 8/22/2024, Page 1., under IV. Policy: All patients of Deaconess Midtown Hospital, Deaconess Gateway Hospital, and Deaconess Cross Pointe and Deaconess Henderson Hospital receiving inpatient,	S 0930	**CORRECTIVE ACTION PLAN** **ISDH Substantiated Complaint #IN00415366 (Date: 10/02/2024)** **Deficiency:** **Corrective Action to be Taken;** *If already corrected, give steps taken and date of correction* *Describe how the facility reviews all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility*	12/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
medina Rasul	Manager of Accreditation and Regulatory	12/02/2024

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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	outpatient, or Emergency Department services will have initial assessment and appropriate follow-up assessments based upon their individual needs. These assessments will include physical, psychological, social/cultural, spiritual and environmental needs. All members of the healthcare team who are involved in direct patient care will participate in the collection of assessment/reassessment data. Page 2. VI. Procedure: A. Assessment framework: The assessment framework will be structured around two components: initial screening and assessment/reassessment of all patients as appropriate to the clinical discipline and the individual patient condition. The assessment/reassessment process is a continuous one, evolving with the patient's changing condition and response to care. Page 3. D. Reassessment 2. Reassessment is ongoing and may be triggered by key decision points and at any interval(s) specified by the departments/ancillary disciplines directly involved in providing patient treatment and/or care. Page 6. 3. Assessment/Reassessment Processes, iv. Completion of skin assessment (4 eyes in 4 hours) with 2 Registered Nurses is required on admission and should be completed within 4 hours of admission and documented by both RNs 2. Review of P3 MR indicated a. Flowsheets from 7/28/23 document P3 up in chair from 1100 hours through 2231 hours, and on 7/29/23 up in chair from 0036 through 0728 hours and P3 returned to bed on 7/29/23 at 1002 hours. b. Lacked documentation of P3 refusal to return to bed evening of 7/28/23 through morning of 7/29/23. c. Lacked documentation of P3 refusal to turn and reposition and/or move from chair.		*took to correct the deficient practice for any client the facility identified as being affected.* **Prevention of Future Deficiencies:** *If prevention includes education, provide educational material and class records or attestations; if it includes monitoring, provide monitoring tool; if it involves a new policy, include the policy; if repairs or PMs are part of the plan, provide appropriate documentation.* **Monitoring:** Describe how the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place) **Responsible Parties for columns 2 and 3** *(Give Titles, not personal names):* **Target Date: Give specific dates** *(Maximum correction time is 30 days from date of survey. If the nature of the deficiency precludes completion within 30 days, the POC must be written in 30-day phases.)* **Status effective Date of Submission of POC** *(Completed or in-progress):* **S930** **Facility Number 005074 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**	

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	3. Review of Complaints and Grievances from 7/1/23 through 10/1/23, indicated the following grievance related to allegations regarding P3: a. On 7/31/23 at 1240 hours facility received a call from a friend regarding P3's stay in A500: states patient was assisted to chair at 1300 hours on 7/28/23 and remained in the chair until approximately 0830 hours on 7/29/23. P3 reported to friend the unit did not have enough staff to assist P3 back to bed throughout the evening/night shift. P3 had surgery on foot and had a wound vac placed and unable to bear weight. b. On 7/31/23 at 1552 hours, N5 interviewed N1 caring for P3 the evening of 7/28/23 through the morning of 7/29/23, he/she stated that when he/she went into the room at 2000 hours to clean the patient up and asked if P3 wanted to return to bed and P3 stated no. When N1 returned to clean P3 up a second time that night, N1 again asked P3 if he/she would like turned/repositioned and P3 again responded no. 4. In interview on 10/2/24 at approximately 1415 hours with N5 (RN Manager of Cardiac Renal Unit), he/she confirmed according to the staffing grid the Cardiac Renal Unit did have minimal staff on both 7/28/23 and 7/29/23 for both RN's and PCT's. N5 confirmed findings and indicated staffing would not be a reason a patient sat up in a chair all night. P3 refused on two occasions to return to bed.		**registered nurse shall supervise and evaluate the care planned for and provided to each patient.** This RULE is not met as evidenced by: S 930 Based on document review and interview, Nursing Services failed to turn and reposition patient every 2 hours for 1 of 5 patient medical records reviewed. (P3) A500 staff will demonstrate understanding and accountability for policy and procedure regarding Moderate/High Risk Braden Score interventions and documentation as outlined in Mosby's P&P Pressure Injury: Risk Assessment and Prevention. Statement of Deficiency was received 11/18/2024. Immediate action taken- this event was included in A500 huddles and unit meeting for discussion regarding the policy and documentation requirements. All Cardiac Renal Unit Staff (A500) will review and be educated on Moderate/High Risk Braden Score Interventions during next A500 Unit Meeting 12/4/2024 and in daily huddles. (Exhibit A) Monitor Compliance of attendance at Unit Meeting to ensure 100% of appropriate Cardiac Renal Unit (A500) staff completion. All A500 staff will be required to attend and	

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			receive information. Sign in Sheet will be collected. Will audit 10 Moderate/High Risk patient records on A500 for turn documentation every month until reach 90% compliance for 3 consecutive months (Exhibit B). After 3 months of 90%, will continue 10 audits quarterly for 3 quarters. If compliance drops below 90%, will increase audits to monthly until 90% achieved for 3 consecutive months. Results will be reported monthly, then quarterly, to the hospital's Regulatory Preparedness meeting and back to staff at A500 Unit Meetings. Audits to be completed by A500 Manager or Team Leader and submitted to report by the last day of each month or quarter. Department Manager of Cardiac Renal Unit and Leadership Team Education by Department meeting will be complete by 12/4/2024.Education to those not in attendance of unit meeting will be completed by 12/20/2024. In progress	