STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150086	A. BUILDING 00 B. WING	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEARBORN COUNTY HOSPITAL	600 WILSON CREEK RD LAWRENCEBURG, IN 47025

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S 0000 Bldg. 00	This visit was for investigation of one State hospital complaint. Complaint Number: 00171162 Substantiated; State deficiencies related to allegations are cited. Date of Survey: 11/4/15 Facility Number: 005077 QA: cjl 12/09/15	S 0000		
S 0812 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E) (F)(G)(H)(I)(J)(K) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following:			

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

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	(A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number,as applicable (F) Documentation of experience in the practice of medicine. (G) Documentation of specialty board certification, as applicable. (H) Category of medical staff appointment and delineation of privileges approved. (I) A signed statement to abide by the rules of the hospital. (J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements. (K) Other items specified by the hospital and medical staff.			
	Based on document review and interview, the medical staff failed to follow rules of the hospital in regard to reviewing patients' home medications for	S 0812	The deficiency will be corrected by the Clinical Content Coordinators and the Vice President of Patient Care Services. #1 – A Medication	03/31/2016

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	1 of 3 closed patient records reviewed, pt. #3. Findings Include: 1. Review of the policy Pre-Admission Medication History, policy number FF-38.1, last reviewed 9/12, indicated the physician will review the Pre-admission Medication History and that medications will be reviewed at admission, daily with the physician profile and at discharge. 2. Review of the medical record for patient #3 indicated there was no documentation, or check off, by the admitting physician, D3, that they had reviewed the patient's home medications and whether or not they wished to stop/hold them, or continue them. 3. At 3:00 PM on 11/4/15, interview with staff member #51, the VP (vice president) of clinical services, confirmed that if the physician does not mark that they have reviewed the patient's home medications, and marked that they wish to discontinue them, or not, it cannot be determined that they did, in fact, review them or that they may have missed them when writing orders for medications while the patient was hospitalized.		Reconciliation policy has been developed that includes physician process and responsibility for Medication Reconciliation. This policy will go to the Medical Executive team for approval on 2/9/16, and the Board of Trustees for approval on 2/24/16. Physician education on the Medication Reconciliation process will be provided at all February Service Meetings and the annual Medical Business Meeting in April 2016. #2 – Will conduct 20 random chart audits in March, April, and May to monitor compliance. #3 – Clinical Content Coordinators and VP of Patient Care Services will be responsible for #1 & #2 above. #4 – Will be corrected by March 1, 2016.	

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S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (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: (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.			
	Based on document review and interview, the nursing staff failed to follow facility policies related to occurrence reporting for 1 of 3 patients who sustained a fall at the facility, pt. #3;	S 0912	The deficiency was corrected by the Vice President of Patient Care Services. #1 - In the November 19, 2015 Nursing Management meeting, the Fall Prevention Program was reviewed and the	12/31/2015

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	and failed to implement the fall policy for 3 of 3 patients who had fallen, patients #1, #2, and #3. Findings Include: 1. Review of the policy Patient, Visitor, or Contract Employee Occurrence Reporting, policy number SAF 316, last revised on 6/12, indicated that each employee who witnesses the occurrence, unusual event, or a disruption of vital service, which occurs within the hospital, should initiate an occurrence report. Under hospital - wide indicators, #5 listed patient or visitor falls. 2. Review of 3 closed medical records, of patients who had fall episodes, indicated patient #3 was noted by nursing staff at 5:28 AM on 3/17/15 by RN (registered nurse P1) that they had responded to a bathroom call light to find the patient on the floor next to the toilet, that F1 had helped the patient to the bathroom, and that the patient "fell forward and slide (sic) down" off the toilet, per the patient and F1 reports. 3. At 4:40 PM on 11/4/15, interview with staff member #54, the risk/quality staff member, confirmed that there was no incident report found, related to the fall of pt. #3, and that one should have been recorded by nursing on 3/17/15. No		Occurrence Report process was reviewed. Direct managers are to review with staff at staff meetings. Fall Risk Program Policy was revised 12/20/15 and mandatory education was given to staff that needed to be completed by 12/31/15. The education included a PowerPoint presentation that reviewed the Fall Risk Program that included a slide that stated “Remember any time a patient falls, you will need to complete the fall prevention intervention, a post fall huddle form, and place the patient in a high risk category including changing the signage.” #2 – The Clinical Supervisor will notify the Risk Manager of any adverse event, including falls. The Risk Manager will monitor for completed occurrence forms that correspond to fall. All falls from 1/1/2016 – 3/31/2016 will be reviewed to assure the patient was placed in a high risk fall category. #3 – Risk Manager and VP of Patient Care Services were/are responsible for #1 & #2 above. #4 –Deficiency has been corrected as the plan of action has been completed and will be monitored for compliance for 90 days.	

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	other documentation was provided prior to exit. 4. Review of the policy Fall Risk Program, policy number AA-36, last revised 5/14/15 indicated the Morse Fall Scale was to be completed upon admission, every eight hours, with a change in patient condition, upon transfer to another unit or when a fall occurs, and to complete a post fall huddle form. 5. Review of 3 patient medical records, of patients who had fallen, indicated that: A. Pt. #1 scored 20 on the Morse scoring tool on admission, fell on 3/19/15 at 12:45 AM, and continued to score 20 throughout the rest of their hospitalization during every 8 hour checks. B. Pt. #2 scored 50 on the Morse scoring tool on admission, fell at 11:10 PM on 3/18/15, and continued to score at 50 with the following checks, except at 8 AM on 3/19/15 when the patient scored at 40. C. Pt. #3 fell at 5:28 AM on 3/17/15 and had no post fall huddle document in the medical record. 6. At 3:00 PM on 11/4/15, interview with staff member #51, the vice president of clinical services, indicated patients #1 and #2 should have increased in scoring			

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	for fall risk by 25 points, as the Morse scoring tool indicates a history of falling, immediate or within 3 months, would have included the facility fall. Nursing failed to score both patients per the policy and Morse tool. No further documentation was provided prior to exit.			