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	150061	A. BUILDING 00 B. WING	06/26/2013

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S000000	This visit was for the investigation of one (1) State complaint. Date of survey: 6-25-13 through 6/26/13 Facility number: 005056 Complaint number: IN00129632 Substantiated; deficiency related to allegations cited Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor QA: claughlin 08/15/13	S000000		
S000930	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 staff interview, the registered nurse failed to assure meals were documented in the medical record for 4 of 5 closed medical records reviewed (patients #1-4), failed	S000930	#1,2,3,4,5,6,7,8,10,16,17 (nutritio n and meal related) How: 1. Provided documentation education to all staff including physicians on proper documentaton of meals,	08/16/2013

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

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	to ensure personal care such as baths and hair shampoo were provided for 7 of 8 patients (patients #1-4, and 6-8), failed to ensure a family member was notified of falls for 1 of 8 patients (patient #2), and failed to ensure nursing staff notified the physician of significant weight loss and poor meal intake for 1 of 8 patients (patient #2). Findings include: 1. Facility policy titled "MEALS/SNACKS" last reviewed/revised 8/8/12 states: "5. The staff member monitoring s patients (known error) at mealtime and snack time will note the percentage of food and fluid consumed by each patient. Percentage of food taken and fluid intake will be documented into the patient electronic medical record for each meal and snack taken." 2. Facility policy titled "NUTRITIONAL ASSESSMENT AND MEALS" last reviewed/revised 8/13/12 states under procedure: "7. Meals/nutritional and fluid intake is monitored by unit staff and recorded on the daily patient flow sheet and recorded on the patient electronic medical record."		supplements and snack. 2. Added to weekly treatment team meeting review of weight loss & meal consumption at which time recommendations for diet changes and nutritional supplementation are made. 3. See attached revised intake and output tab that now requires % of meal consumed. All staff document into the electronic record Prevent from reoccurring: 1. Physicians are reviewing weight and meal intake and are documenting in progress notes on regular basis. 2. New chair weight scale has been purchased to replace old scale. 3. Review of meal plans is underway to include more finger foods especially for physically challenged patient who have problems eating with utensils. 4. Auditing of documentation is being done on a weekly basis and feedback is provided to staff. Individual education provided 1:1 as needed. Findings are being reviewed during monthly staff meetings. 5. Revised shift report tool to reflect admission, current weight, meal consumption, and supplements. Responsible: Program Director and Nurse Manager #9,11,12,13,14,15,16,18 (bathing/ hygiene) 1. Educated staff regarding documenting ADL's by listing care provided rather than writing global statements such as "provided total care". 2. Setup shower and shampoo schedule,	

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	3. Review of patient #1 medical record indicated the following: (A) He/she was admitted to the BHU on 4/19/13 and discharged on 5/9/13. (B) A problem was identified with documentation of meal consumption in the medical record. The record lacked documentation of consumption for breakfast and lunch on 4/30/13. Staff were able to find the meal consumption amounts documented on CNA daily worksheets on the unit, however the worksheets are not part of the medical record. 4. Review of patient #2 medical record indicated the following: (A) He/she was admitted to the BHU on 4/22/13 and discharged on 5/16. (B) A problem was identified with meal consumption in the medical record . The record lacked documentation of meal consumption on 4/30/13, 5/2/13, 5/7/13, 5/9/13, and 5/12/13. Staff were able to find the meal consumption recordings documented on CNA daily worksheets on the unit, however the worksheets are not part of the medical record. (at times there was a 0 or only bites for the patients intake). 5. Review of patient #3 medical record indicated the following: (A) He/she was admitted to the BHU on		daily updates given during shift report. 3. Review ADL needs during treatment team meetings on weekly basis. 4. See attached ADL tab, all staff document into the electronic record Prevent from reoccurring: 1. Audit weekly documentation of ADL's and provide feedback to staff and provide 1:1 education as needed. Findings are discussed during monthly staff meetings. Responsible: Program Director and Nurse Manager #10E, 16C, 16E,19 (Notification) How: Re-educated staff to call physician and responsible party regarding falls and other unusual occurrences. Prevent from reoccurring: 1. Reviewing/auditing event documentation and providing feedback to individuals as needed, and discuss findings during staff meeting. Responsible: Nurse Manager	

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	4/22/13 and discharged on 5/2/13. (B) A problem was identified with meal consumption in the medical record. The medical record lacked documentation of meal consumption for breakfast on 4/24/13, breakfast and dinner on 4/25/13, lunch and dinner on 4/26/13, breakfast, lunch and dinner on 4/28/13, lunch and dinner on 4/29/13, and breakfast and lunch on 4/30/13. Staff were able to find the meal consumption recordings documented on CNA daily worksheets on the unit, however the worksheets are not part of the medical record. 6. Review of patient #4 medical record indicated the following: (A) He/she was admitted 4/22/13 and discharged on 5/1/13. (B) A problem was identified with meal consumption in the medical record. The medical record lacked documentation of meal consumption for breakfast and dinner on 4/23/13, breakfast, lunch and dinner on 4/25/13, breakfast and lunch 4/26/13, breakfast, lunch and dinner on 4/27/13 and 4/28/13, and breakfast and lunch on 4/30/13. Staff were able to find the meal consumption recordings documented on CNA daily worksheets on the unit, however the worksheets are not part of the medical record.			

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	7. Staff member #3 verified in interviews conducted beginning at 3:40 p.m. on 6/25/13 that there was a problem with meal consumption documentation for patients 1-5. 8. Staff member #1 verified in interviews conducted beginning at 11:20 a.m. on 6/26/13 that there was a problem with meal consumption documentation for patients 1-5. 9. Review of patient #1 medical record indicated the following: (A) He/she was admitted to the BHU on 4/19/13 and discharged on 5/9/13. (B) A problem was identified with bathing during the hospital stay. There was no documentation that the patient received a bath or shower on 4/24, 4/29, 4/30, 5/1, 5/3 and 5/6. There was only one day (4/23) that it was documented that the patient had his/her hair shampooed. 10. Review of patient #2 medical record indicated the following: (A) He/she was admitted to the BHU on 4/22/13 and discharged on 5/16/13. (B) A problem was identified with lack of physician notification that the patient had no meal intake on numerous occasions including, but not limited to, lunch and dinner on 5/7/13, breakfast,			

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	lunch, and dinner on 5/11/13, breakfast and dinner on 5/12/13, breakfast, lunch, and dinner on 5/14/13 and breakfast, lunch and dinner on 5/15/13. The patient consumed only "bites" of meals at lunch on 5/9/13 and only "bites" at lunch on 5/12/13. (C) The discharge nursing summary report was not accurate. The document dated 5/16/13 at 4:58 p.m. stated "adequate Diet/Liquid Intake". (D) The patient lost 23.4 pounds during his/her stay. His/her admission weight was 167 pounds and his/her discharge weight was 143.60. The medical record lacked documentation that the physician was notified of the weight loss. (E) The patient had a fall on 4/28/13 at 8:30 p.m., on 4/30/13 at 7:10 a.m., and on 5/1/13 at 6:35 p.m. The record lacked documentation that the spouse was notified. (F) A problem was identified with bathing during the hospital stay. The record lacked documentation that a bath or shower was completed on 4/26/13 through 5/1/13, 5/3/13, 5/6/13, 5/7/13, 5/10/13, 5/11/13, and 5/13/13. According to the medical record, the patient did not have his/her hair shampooed during the visit. 11. Review of patient #3 medical record indicated the following:			

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	(A) He/she was admitted to the BHU on 4/22/13 and discharged on 5/2/13. (B) A problem was identified with bathing during the hospital stay. The record lacked documentation that the patient received a bath or shower on 4/26/13, 4/27/13, 4/29/13, and 5/1/13. 12. Review of patient #4 medical record indicated the following: (A) He/she was admitted on 4/22/13 and discharged on 5/1/13. (B) A problem was identified with bathing during the hospital stay. The record lacked documentation that the patient received a bath or shower on 4/23/13, 4/26/13, 4/27/13, and 4/29/13. The record lacked documentation that the patient had their hair washed during the stay. 13. Review of patient #6 medical record indicated the following: (A) He/she was admitted to BHU on 6/21/13. (B) A problem was identified with bathing. The record lacked documentation that the patient received a bath or shower on 6/23/13 and 6/24/13. The record lacked documentation that the patients hair wash was washed. 14. Review of patient #7 medical record			

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	indicated the following: (A) He/she was admitted to BHU on 6/17/13. (B) A problem was identified with bathing. The record lacked documentation that the patient received a bath or shower on 6/19/13, 6/21/13, 6/23/13, and 6/24/13. 15. Review of patient #8 medical record indicated the following: (A) He/she was admitted to BHU on 6/21/13. (B) A problem was identified with bathing. The record lacked documentation that the patient received a bath or shower on 6/23/13 and 6/24/13. 16. Staff member #3 indicated the following in interviews conducted beginning at 3:40 p.m. on 6/25/13: (A) Nursing assistants give baths on the unit daily unless the patient refuses. The unit has a shower. (B) He/she verified that the medical records lacked documentation of bathing/shower and hair wash for the medical records reviewed. (C) He/she verified that the spouse of patient #2 was not notified of falls. (D) He/she verified that patient #2 had a weight loss or poor intake and there was no documentation that the physician was			

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	notified or interventions put into place prior to 5/15/13. (E) When asked if the circumstances of patient #2's falls would warrant family notification, he/she indicated that family should have been notified. 17. Staff member #4 verified at 1:00 p.m. on 6/26/13 that the medical record for patient #2 lacked documentation that the physician was made aware of the weight loss and poor intake during his/her stay. He/she verified that the physician progress notes and the treatment plan lacked information related to the poor intake and the weight loss. 18. Facility policy titled "PERSONAL CARE (PATIENT HYGIENE & GROOMING NEEDS) last reviewed/revised 8/7/12 states under policy: "In accordance with the patient's needs and with due regard for privacy, personal hygiene and grooming are taught as indicated and maintained, particularly bathing, brushing teeth, caring for hair and nails, and using the toilet." Under procedure, the policy states: "2....Patients will be assisted with personal hygiene activities as indicated." 19. Facility policy titled "Incident			

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	Report Policy" last reviewed/revised 7/12 states on page 3: "2. Information to be entered on the Incident Report includes (items with * MUST be completed).... and page 4 states: "L. *Notification of supervisor, MD, administrator on-call and/or family to include who was contacted, when and by whom,....."			

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