Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 010005	**(X3) Date Survey Completed** 03/23/2017
Name of Provider or Supplier Marshall Medical Centers South Campus	**Street Address, City, State** 2505 U S Highway 431 North, Boaz, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on medical record review, Patient Fall Report, interviews and review of policy and procedure, staff failed to remain in the shower room with Patient Identifier (PI # 1), a patient identified as a fall risk. As a result of this lack of supervision, PI # 1 fell resulting in pain to his/her bilateral knees. Findings include: I. Medical Record Review: PI # 1 was admitted to the hospital on 2/27/17 with a chief complaint of shortness of breath, headache and cough. History of Present Illness: "Reports she started getting sick about two days ago with a headache, body aches and a low grade temperature. Has also had abdominal pain and nausea with a couple of episodes of vomiting. Medical History: Chronic Obstructive Pulmonary Disease (COPD) on 2 Liters Oxygen via nasal cannula, Transient Ischemic Attack, Congestive Heart Failure, Parkinson's Disease and Dementia. Assessment: 1. Acute on Chronic Hypoxic Hypercarbic Respiratory Failure (abnormally-high level of carbon dioxide in arterial blood, normalbreathing.com). 2. Acute exacerbation of COPD. 3. Abdominal Pain, Nausea, Vomiting. 4. Hyperglycemia (high blood sugar). 5. Dementia. 6. Parkinson's Disease. 7. Hypertension. Plan: 1. Start Intravenous antibiotics, steroids and breathing treatments. 2. Place on pattern blood sugars. 3. Check Hemoglobin A1c (reveals average level of blood sugar over the past 2 - 3 months, web.md.com)..." - Patient Progress Notes (Nursing Notes): 3/6/17: 8:29 AM: Oxygen; 2.5 Liters per minute via nasal cannula Oxygen Saturation: 97% (noninvasive method for monitoring peripheral oxygen saturation) Blood Pressure: 114/60 Respirations: 20 Pulse: 97 Cardiovascular Assessment: Regular rate and rhythm. Nail beds pink. Capillary refill less than 3 seconds. Telemetry (monitor) Rhythm: Sinus Rhythm... (normal heart rhythm). Injury Risk Assessment: Mobility: Needs assistance to

ambulate. Intravenous Assessment: 1/2 Normal Saline infusing at 21 milliliters per hour to left forearm. Metabolic /Integument Assessment: Overview: Intact. Skin Alteration:...Bruise to bilateral arms. DVT (Deep vein thrombosis) Prophylaxis: SCDS on patient and in use. (Sequential Compression Device: a method of DVT prevention that improves blood flow in the legs and helps prevent blood clots, med. umich.edu). Patient is taking Lovenox (medication that helps reduce the risk of deep vein thrombosis, lovenox.com). Musculoskeletal Assessment: Steady gait. Moves all extremities. Neurological Assessment: Alert and oriented. Pulmonary Assessment: Bilateral breath sounds clear to auscultation. Dyspneic at rest and on exertion (Short of breath). 5:18 PM: Patient (PI # 1) fell out of the shower chair on to her knees. Dr. (last name of hospitalist/ physician) called. X-ray ordered of knees. Patient rates pain at 8/10. " PRN given." (PRN- as needed medication) for pain. 6:00 PM: Patient lying on back. Head of bed elevated. 7:03 PM: Pulse 87. Oxygen @ 2 Liters per minute per nasal cannula. Oxygen Saturation: 92 %. - Patient Fall Report Dated 3/16/17 at 5:18 PM Nurse Completing Report: Name of Registered Nurse (RN) / Employee Identifier (EI # 1) 1. Admission Diagnosis: COPD Exacerbation Date/Time of Fall: 3/6/17 at 4: 30 PM RN / Team member who reports fall: Name of Patient Care Assistant (PCA) /EI # 2. 2. Details of Fall: Patient (PI # 1) rolls off bed/chair onto the floor 3. Was fall toileting related? Yes. "Shower." 4. If ambulatory, has non-skid footwear? No documentation. 5. Was fall risk completed within 24 hours of Admission? Yes. Was the patient (PI # 1) on the Fall Prevention Program prior to the fall? Yes. ...8. Was the patient on any sedating medications...? Depakote ER 500 milligrams (mg.) and Neurontin 600 mg at bedtime. 9. Time of last round: No documentation. Call light in reach: No documentation. 10. Physician notified of fall? Yes. X-rayed? Yes. Family Notified? Yes. 11. Was patient (PI # 1) injured from fall? No. Patient states that knees hurt. X- rays were made of patient's knees. No evidence of fracture or dislocation. ...13. Categorize the fall: Anticipated Physiological (occur in patients who have risk factors identified in advance - abnormal gait, dementia, etc. II. Interviews: During an interview on 3/21/17 at 1:30 PM, the RN Nurse Manager (EI # 1) stated PI # 1 ambulated to the hall shower with EI # 2 on 3/6/17. EI # 2 placed PI # 1 in a shower chair. EI # 2 walked out of the shower room to get something for the patient (PI # 1). The patient fell from the chair to the floor on both knees. PI # 1 said, "I think I just jarred myself." Complained of pain in both knees. The RN (EI # 1) said she called the physician and x-rays of the knees were order. PI # 1 reported to EI #1 that she reached to adjust the water and slid out of the chair. Afterwards, PI # 1 complained of knee pain. EI # 1 said she pulled the covers down and felt the patient's knees. There was no brusing or broken skin. The knee x-rays were negative. "Normally we don't leave a fall risk (patient) alone." PI # 1 was cognitively intact. During an interview on 3/21/17 at 2:30 PM, The Patient Care Assistant / EI # 2, assigned to care for PI # 1 on 3/6/17 reported she walked beside PI # 1 as the patient ambulated to the shower room. EI # 2 stated she assisted PI # 1 into the shower chair. The surveyor asked EI # 2 if she locked the shower chair and EI # 2 replied, "I thought I did." EI # 2 adjusted the water temperature. EI # 2 said she then left PI # 1 in the shower room and went to get some items for the patient from the patient's room. PI # 1's daughter arrived and found PI # 1 in the shower room. PI # 1's daughter came out of the shower room and stated PI # 1 had fallen. "I went in there." EI # 2 reported PI # 1 was on her knees trying to get back in the shower chair. EI # 2 said she put a gown on the patient, helped PI # 1 into a wheelchair and took PI # 1 back to her room. According to EI # 2, "The patient seemed fine. I got a nurse to come in the room" to check PI # 1. During an interview on 3/22/17 at 4:00 PM, the RN Nurse Manager (EI # 1) stated she looked at PI # 1 after the fall. According to EI # 1 she was in another room taking care of a patient who had pulled her IV (intravenous) out when PI # 1 fell. When EI # 1 came out of

room 316 for supplies, staff advised her of PI # 1's fall. Other staff RN's responded immediately to PI # 1 after the fall. EI # 1 said she went as soon as possible to evaluate PI # 1 after completing care for the patient in 316. "I looked at her (PI # 1's) knees. There was no bruising. I called the doctor and gave the patient some pain medication." III. Policy and Procedures: Date of Last Revision: 8/2013 Nursing Service Policy: Fall Prevention Purpose: To systematically identify patients at risk to fall and direct the individualized plan of care to reduce fall risk. Definition of a Fall: An unplanned descent to the floor. This will include an assisted lowering of the patient to the floor and patients who are found lying on the floor unable to account for their situation. Policy: "All inpatients will be assessed for fall risk during the admission process. A plan of care based on identified risk factors will be implemented. Fall risk will be reassessed and updated once daily, or with a significant change in patient's condition...Fall risk will be included in hand off communication. Patients should be considered at a higher risk of injury from a fall if they are over the age of 85, have a bone disorder (osteoporosis, receiving radiation), have coagulation disorders or therapies (bleeding problems, receiving anticoagulant therapy), or have had recent surgery... Assessment of Fall Risk for Inpatients: The Morse Fall Scale will be used to determine the risk level for fall. The risk assessment will be performed with the admission assessment. The score will be entered and the patient categorized as: No risk 0-24 points Low to Moderate risk 25-45 points... Falls: Morse Fall Scale History of falling: 25 points - patient has fallen during this hospitalization or history of falls within last three months. Secondary Diagnosis: 15 points -More than one medical diagnosis is active for current admission... Ambulatory Aides: 0 points - The patient walks without a walking aide (even if assisted by a nurse)... Intravenous Therapy: 20 points - The patient has an IV, saline lock, or is attached to equipment... Gait: 0 points - The patient has a normal gait... Mental Status: 0 points - The patient's mental status is normal. Interventions to Reduce Falls: Low to Moderate Risk- Apply yellow fall risk identifier to patient. Educate patient /family about fall risk. Instruct patient to be up with assistance only. Toileting offered with rounding..."