STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 000	INITIAL COMMENTS An Abbreviated Survey investigating Complaint KY 24912 was initiated on 06/14/16 and concluded on 06/21/16. The Division of Health Care found the allegation to be substantiated. Based on the findings, it was determined the Condition of Participation: Nursing Services 42 CFR 482.23 (A 0385) under standard A 0392 was not met. Based on interview, record review, and a review of the facility's policies, it was determined the facility failed to ensure adequate nursing services were provided to meet the needs of patients for three (3) of twenty-four (24) sampled patients (Patient #20, #21, and #22). Based on the survey findings it was determined the Conditions of Participation at 42 CFR 482.23 Nursing Services was not met. Patient #20 was intubated and vomited without suction equipment available because there were no ancillary staff to restock the Emergency Department (ED) room between patients. Patient #21 was status post abdomen surgery and experiencing pain; however, the patient had to wait for over an hour to receive the ordered pain medication. Patient #22 sustained a fall with minor injuries when the patient fell from the bed in a Critical Care Unit. The patient's nurse was in another patient's room and two (2) of the four (4) nurses were off the floor with patients in radiology. Multiple interviews with physicians and nurses revealed staffing was a problem and affecting patient safety.	A 000		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or	A 385		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

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UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 385	Continued From page 1 supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on interview, record review, and a review of the facility's policies, it was determined the facility failed to ensure adequate nursing services were provided to meet the needs of patients for three (3) of twenty-four (24) sampled patients (Patient #20, #21, and #22). Based on the survey findings it was determined the Conditions of Participation at 42 CFR 482.23 Nursing Services was not met. Patient #20 was intubated and vomited without suction equipment available because there were no ancillary staff to restock the Emergency Department (ED) room between patients. Patient #21 was status post abdomen surgery and experiencing pain; however, the patient had to wait for over an hour to receive the ordered pain medication. Patient #22 sustained a fall with minor injuries when the patient fell from the bed in a Critical Care Unit. The patient's nurse was in another patient's room and two (2) of the four (4) nurses were off the floor with patients in radiology. Multiple interviews with physicians and nurses revealed staffing was a problem and affecting patient safety. Refer to A0392.	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 2	A 392		

needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on observation, interview, record review, and review of staffing schedules, facility's policies, and diversion information, it was determined the facility failed to ensure an adequate number of qualified professional nursing personnel were available to provide nursing care according to facility policy, staffing patterns, and physician orders for three (3) of twenty-four (24) sampled patients. (Patients #20, #21, and #22). There was no suction equipment when Patient #20 vomited while intubated related to no ancillary staff to restock the Emergency Department (ED) rooms. The patient was being held because there was no bed in the Medical Intensive Care Unit (MICU). Patient #21 was status post abdomen surgery and experiencing pain; however, the patient had to wait for over an hour to receive the ordered pain medication. Patient #22 sustained a fall with minor injuries when the patient fell from the bed in a Critical Care Unit. The patient's nurse was in another patient's room and two (2) of the four (4) nurses were off the floor with patients in radiology.

In addition, interviews with physicians, nurses, and leadership revealed there was a nursing shortage and had been a problem for some time. The nursing shortage resulted in beds being closed in the units and trauma patients were being held for hours in the ED.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 3 Review of the facility's policy, Staffing for the Emergency Department, reviewed January 2015, revealed staff was assigned to meet patient base staffing that was derived from current productivity schedule. Staff experience levels were considered when making individual assignments. Assignments were completed daily by the Charge Nurse. If appropriate and adequate staff was not available to meet patient care needs based on census and acuity, the Charge Nurse would notify the Clinical Managers. The daily base minimum staffing pattern for the ED at 7:00 AM would be one (1) Charge nurse, nine (9) Registered Nurses, and five (5) Technicians. At 11:00 AM add one Registered Nurse (RN), at 1:00 PM add one RN and one (1) ED Technician, at 3:00 PM add one RN. At 7:00 PM, the staffing would be one (1) Charge Nurse, nine (9) RNs, and five (5) Technicians. Review of the facility's policy, Emergency Severity Index Triage, General Guidelines-Protocol for Triage of Emergency Department Patients, reviewed 02/16/15, revealed five (5) acuity levels. Triage Level One-Resuscitation, revealed the patient presented to the ED with the need for immediate lifesaving interventions. Review of Triage Level Two- Emergent, revealed the patient presents with a condition posing a potential treat of life, limb or function and requires rapid medical intervention and utilization of multiple resources. Review of Triage Level Three-Urgent, revealed the patient presented with a condition that could progress to a serious problem requiring emergency intervention. Review of Triage Level Four-Semi-Urgent, revealed the patient presented with a condition that has a low potential for deterioration or complications. Review of Triage Level Five-Non-Urgent, revealed the patient	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 4	A 392		

presented with a condition that may be acute but was not urgent. The condition may be part of a chronic problem with or without evidence of deterioration.

Review of the facility's policy, Floating and Canceling of Nursing Staff, reviewed June 2013, revealed staffing assignments would be made to ensure that patient needs were met. The units would continue to be responsible for their own staffing and must try to cover their needs before asking for assistance from other units. Each unit was to be staffed according to core staffing guidelines. All staff may be pulled to any unit based on their competencies.

Review of the facility's Diversion Policy, reviewed January 2015, revealed there were three (3) levels of diversion as follows: 1. Critical Care Diversion-there were no Critical Care beds available but Medical/Surgical beds were available; 2. Medical Surgical Diversion-there were no Medical/Surgical beds but Critical Care beds were available; 3. Total Bed Division- there were no Critical Care or Medical/Surgical beds available. Only trauma, psychiatric, oncology, stroke, and high-risk obstetrical patients would be accepted. Departments affected: Nursing, ED, and ED physicians.

Review of the job description for the Vice President/Chief Nursing Officer (CNO), reviewed 12/26/05, revealed the CNO would plan, direct, coordinate, and evaluate nursing care to patients. One of the essential functions performed would be to schedule staff to meet patient care needs while utilizing flexible staffing techniques. In addition, the CNO would actively support all departmental scheduling and staffing policies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 5	A 392		

procedures. Develop, coach, and mentor staff on issues related to effective scheduling and staffing guidelines.

Review of the job description for a Clinical Nurse Manager, reviewed April 2015, revealed the manager would be responsible for overall operations of the nursing unit.

Review of the job description for a Charge Nurse, revised 09/05/13, revealed the Charge Nurse would assist the Clinical Manager with the management of the unit including staffing and scheduling. Review of the essential functions of the Charge Nurse revealed they would delegate workload appropriately and fairly to meet the needs of the patient. They would assign patients and tasks according to staff expertise and patient acuity and would be required to provide direct patient care as needed while balancing patient care duties with charge nurse duties.

1. Review of Patient #20's clinical record revealed the patient arrived at the hospital on 06/10/16 at 08:36 AM via Emergency Medical Service (EMS). The patient was immediately taken to Trauma Room 9 for treatment. EMS had given the patient 2 mg of Narcan IV related to history of heroin drug abuse. At 9:11 AM, the patient was successfully intubated after several attempts and placed on a ventilator. Oral tube for decompression was placed at 9:17 AM. The patient went to have a CT scan of the head at 9:22 AM. At 9:51 AM, the patient was moved to Emergency Department (ED) Room 21.

Review of the ED physician notes, dated 06/10/16 at 9:38 AM, revealed the patient was in critical condition with deterioration of the airway. An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 6	A 392		

addendum was added at 12:56 PM that revealed the patient was in renal failure and would be admitted to the Medical Intensive Care Unit (MICU) for Aspiration Drug Overdose, Acute Renal Failure secondary to lung down time.

A telephone interview with Physician #2, on 06/17/16 at 5:09 PM, revealed he had intubated Patient #20 in Trauma Room 9 and the patient was a very difficult intubation. The physician stated the patient was transferred to a regular ED Room awaiting for a bed in the MICU because there were no beds available. A little time later, he recalled the nurse yelling "help", "help", and when he entered the ED room, the patient was vomiting large amounts of coffee ground emesis. There was no suction equipment in the room so the nurse had to search for suction equipment. The physician stated the patient clearly needed to be in a Critical Care Unit for closer monitoring where the patient to nurse ratio was better. He stated the nurse could not have provided the appropriate monitoring of this patient because she had three (3) other patients to care for and the ED was very busy. He stated that he felt like the patient's safety was compromised.

Interview with Registered Nurse (RN) #6, on 06/20/16 at 3:40 PM, revealed she was the nurse responsible for Patient #20 in the ED on 06/10/16. She stated the patient had arrived at the hospital via EMS and taken to Trauma Room #9 where the patient was orally intubated and placed on a ventilator. She stated the patient was stabilized and then moved to a regular ED room (Room #21) to be monitored. According to the nurse, the patient had been sedated and had an Oral Gastrotomy Tube for decompression. However, she was waiting for an X-Ray to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 7	A 392		

confirm the tube was in the stomach before connecting to suction. She stated the ventilator alarms sounded and when she went into the patient's room, she saw the patient vomiting large amounts of coffee ground emesis around the ET tube. In addition, the patient was waking up from the sedation medication and was fighting the tube. The patient's systolic blood pressure dropped to the sixties (systolic pressure is considered normal at 120). She went to suction the patient and found no suction equipment in the room. The room had not been restocked after the previous patient. She stated she had to go to the next ED room and obtain the suction equipment. According to the nurse, she suctioned four hundred (400) milliliters of coffee ground emesis from the patient's stomach. She stated normally the ED Technicians would restock the ED rooms between patients and ensure equipment was available. However, there was no Technician working that day.

Continued interview with Registered Nurse (RN) #6 revealed she had voiced her concerns to the Charge Nurse regarding not being able to check on her other three patients because this patient required one on one monitoring because of the patient's critical needs. She stated the patient was being held in the ED waiting for a bed in the Intensive Care Unit (MICU) and needed to be moved for close monitoring. However, she had been told there was difficulty finding a bed. According to RN #6, the ED Charge Nurse closed four beds in the ED at that time because there were not sufficient staff to care for the patients. She stated the patient's safety was a big concern to her and she feared something would happen to the patients or her nursing license. She stated the Medical Director of the ED informed the Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 8	A 392		

Nursing Officer (CNO) of this event and the nurse had documented the event in a Patient Safety Note (PSN). She did not know if the event was investigated. The nurse stated frequently the ED rooms were not stocked with necessary equipment (i.e. IV pumps, poles, and suction canisters) and the nurse would have to go from room to room searching for these items. This took valuable time away from the patient.

Interview with RN #5, on 06/16/16 at 8:10 AM, revealed he was the Charge Nurse for the ED on 06/10/16. He stated one of the scheduled nurses had called in sick leaving the ED short. He stated Trauma Room 9 had to be staffed for incoming trauma patients so he pulled a nurse to cover the trauma room and closed ED Rooms #22, #23, #30 and Hallway Bed #9 for approximately four (4) hours (7:00 AM-11:00 AM) until he could find coverage. He stated it took eleven (11) nurses to cover the ED and when they were short one, it really hurt. According to RN #5, the ED was very busy that day and they had patients in the hallway beds. He stated there had been a large turnover in staff approximately eight (8) to ten (10) months ago and the ED lost a lot of experienced nurses. He added the hospital was using Travel Nurses to fill positions.

Review of the nursing schedule for 06/10/16 revealed there were nine nurses to cover Trauma Room 9 and the other thirty (30) ED beds from 7:00 AM to 11:00 AM. The scheduled reflected a call-in with no replacement.

Interview with the Director of Nursing Services in the ED, on 06/16/16 at 4:59 PM, revealed she had been informed of the incident by Physician #2 because he was very upset this had occurred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 9	A 392		

The physician was upset there was no suction equipment in the ED room and felt the patient could have aspirated. In addition, the physician was upset because the patient was being held in the ED and not admitted to the Critical Care Unit where the patient to nurse ratio was 2:1 (two patients to one nurse). She stated there had been an investigation of the incident; however, there was no documentation in the electronic record.

A previous interview with the ED Director of Nursing, on 06/14/16 at 8:10 PM, revealed the staffing ratio for the ED was 4:1 (four patients to one nurse). All nurses are RNs and certified in Pediatric Advance Life Support (PALS) and Advance Cardiac Life Support (ACLS), and other accreditation. She stated staffing patterns had changed with the present Corporation. She now looked at productivity staffing and she said the ED had lost a lot of experienced nurses. She indicated staffing goes up and down based on current census. She validated there had been problems with holding patients in the ED for extended periods of time because there were no beds available on the units. She stated the physicians discharge patients from the units throughout the day and in the evenings there are more beds available.

Interview with Risk Management, on 06/20/16 at 2:26 PM, revealed he recalled discussing the event regarding no suction equipment available. He stated the ED conducted Huddle meetings at 7:00 AM and 7:00 PM. These meetings included the nurses, physicians, and other staff of both shifts and were conducted at the beginning of each shift . The purpose of the meetings was to discuss any safety events and give report on patients that remained in the ED from the other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 10	A 392		

shift. He recalled the patient did vomit dark, coffee ground emesis. He did not know if the incident was treated as a event report and investigated. He was unable to locate the Safety Q/R Manager Review form related to this event. Review of the electronic record revealed no documentation of the event. At 9:40 AM, the nurse had performed an assessment of the patient. The electronic record revealed the patient was admitted to the Critical Care Unit later that evening on 06/10/16 at 7:49 PM. The resident was discharged from the hospital on 06/13/16.

2. Review of the Safety Q/R Manager Review form (event form), dated 05/20/16, revealed Patient #22 sustained a fall from the bed in a Critical Care Unit sustaining minor laceration to the mouth and head. A nurse on the unit had documented the event. According to the event report the fall was unwitnessed. The report revealed a safety huddle was performed and determined the side rails were flush to the patient's bariatric mattress and the patient had rolled over the side rails into the floor. The event detail note revealed the resident's fall occurred when the unit was down a nurse because the nurse had accompanied another patient to a CT scan. Under factors contributing to the event the nurse documented high acuity patients with not enough staff.

Interview with RN #16, on 06/20/16 at 8:48 AM, revealed she was working on the unit when the patient had the fall. She was in another patient's room and a nurse had taken a patient to CT scan on another floor. She stated "nobody had eyes on this patient" at the time of the fall. She revealed she had worked at this hospital as a Travel Nurse since January 2016. She stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 11	A 392		

biggest risk to patient safety was when a nurse had to take a patient off the unit for a procedure and leave other patients under the care of nurses who already had two (2) to three (3) patients to monitor. She said it was the hospital protocol to have a nurse accompany a patient to procedures which occurred off the unit. She stated when nurses go off the floor, it placed patient safety at risk because the remaining nurses have to monitor additional patients.

Review of the assignment sheet revealed Patient #22 was assessed to be confused.

Interview with RN #10, on 06/20/16 at 9:01 AM, revealed the staffing ratio for the Critical Care Unit was 2:1 (two patients for one nurse). The nurse stated she was concerned when a nurse was off the unit with their patient because that left another nurse with three (3) or four (4) patients to monitor. She stated she had worked when Patient #22 had fallen over the side rail onto the floor hitting his/her head. There had been two nurses off the unit, and the patient's nurse was in another patient's room caring for a critically ill patient when Patient #22 fell. She stated this past weekend there were only three (3) nurses to care for ten (10) patients. She stated the House Supervisor would sometimes block beds and not admit new patients if there were not enough staff to care for the patients.

Interview with the Risk Management, on 06/20/16 at 3:30 PM, revealed the fall was investigated and they determined the bariatric mattress was flushed with the side rails and when the patient rolled over, he/she fell onto the floor. According to the Risk Manager they had not considered staffing as the root cause of the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 12	A 392		

Review of the staffing scheduled for 05/20/16, the day the patient fell, revealed there were four (4) nurses for ten (10) patients for both the day and night shift. Per the staffing schedule, two nurses had three (3) patients and if a nurse had to be off the floor, the other nurses would pick up their patients. One patient was scheduled for a CT scan on day shift and three (3) patients were scheduled for testing off the floor on the evening shift.

3. Record review for Patient #21, revealed on 06/10/16, the patient had surgery for a ventral hernia repair and colostomy reversal. The surgeon ordered Oxycodone 10 mg (1) every four (4) hours as needed (PRN) for mild pain (1-3) and 15 mg (1) every four (4) hours/PRN for moderate pain (4-6). In addition, the physician ordered Tylenol 1,000 mg (1) every six (6) hours routine starting on 06/13/16. The nurse assessed the patient to be awake, alert, and oriented to person, place and time.

Observation of Patient #21, on 06/20/16 at 10:05 AM revealed RN #8 administering medication to the patient. The nurse revealed the patient was given pain medication as requested.

Interview with Patient #21, on 06/21/16 at 10:25 AM, revealed he/she was being discharged home today. The patient stated he/she was very disappointed with the care they received in this unit. The patient stated he/she had to wait for long periods of time for his/her pain medication. The patient stated he/she had abdominal surgery to remove a colostomy and reconnect the colon and experienced pain. The patient stated the surgery went well but the post operative care had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 13	A 392		

not been good. Patient #21 stated whenever he/she activated the call light, someone would answer and tell the patient they would be right there. However, the patient stated he/she had waited up to an hour for the requested pain medication and by the time the patient received the pain medication they were hurting bad. In addition, the patient revealed two (2) days ago, he/she had requested assistance to toilet. The patient had activated the call light and someone answered and told the patient they would be right there. The patient stated they waited and waited and became incontinent of bladder while waiting. The patient stated he/she was embarrassed and when the nurse came in, the nurse told the patient to wear an incontinent brief. According to the patient, he/she was continent at home and had worn regular underwear. In addition, the patient alleged he/she had not been walked according to their physician's orders because the staff were too busy.

Interview with RN #8, on 06/20/16 at 10:50 PM, revealed she had been in another patient's room that was having trouble breathing and was unaware Patient #21 had requested pain medication. The nurse revealed the patient had told her they had been waiting for the pain medication for over an hour. According to the nurse, the patient had rated their pain to be a eight (8) on the scale of 1-10. The nurse stated the unit used a communication device called Vosara (like a walkie-talkie) and the Unit Secretary was supposed to inform the nurse when their patient needed anything. However, the Unit Secretary for today was pulled from another unit and had not given the devices to the nurses. She stated the devices were usually given to the nurses at the beginning of the work shift (7 AM).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

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A 392	Continued From page 14	A 392		

The nurse stated the ancillary staff (Tech) had been cut and the nurse had to do everything. She stated at times staffing ratio was five (5) patients to one nurse. It was supposed to be 4:1. According to the nurse, when there is no Tech working, the nurse must ambulate the patients, give baths, assist with toileting, make beds, and many other non-nursing tasks. She felt due to insufficient staffing, patient safety could be compromised and Post-OP care not provided according to protocol.
Interview with the Unit Secretary, on 06/20/16 at 11:00 AM, revealed she had been pulled from another unit and had not worked this unit before. She did not know to give the Vosara devices to the nurses.
Interview with RN #9, on 06/20/16 at 9:57 AM, revealed the staffing ratio for the Post-Op Unit (SICU) was 4:1 (four patients to one nurse). She stated often during the night shift there would be five (5) to six (6) patients to one nurse. She revealed this unit took care of patients after surgery with special needs such as new Tracheotomy, lines, drains, and pain control that needed to be taken into consideration when staffing the unit. She stated the patient's safety would be compromised when a patient did not get their pain medication timely or walked according to the surgeon's orders.

Multiple interviews with physicians and nurses revealed staffing was a problem and affecting patient safety.
A previous interview with the ED Medical Director, on 06/15/16 at 2:05 PM, revealed there was a concern among the physicians that experienced nurses in the ED had left after the layoffs and the positions had been filled with Travel Nurses and new nurse graduates. He stated this hospital was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 15	A 392		

different from the surrounding community hospitals because it was the only Level One Trauma Center and an Academic teaching hospital with a close relationship with the local School of Medicine. He stated this ED saw large volumes of patients with high acuity levels. He stated a trust system must exist between the physicians and nurses because they work so closely together in the ED. He revealed there had been a 20% turnover rate since the layoffs and the corporation did not understand the fear that created, and the uniqueness of this hospital. According to the Medical Director, many physicians (including himself) had voiced their concerns about patient safety to leadership. Leadership had told them they were working on the issue, but the problem had been going on for a long time. He stated the physicians were frustrated because they could not get their patients admitted to the units timely. Patients were being held in the ED for hours (daily) and these were critically ill patients that needed close monitoring only a unit could offer. He stated on 06/14/16, at least one third (1/3) of the ED beds had patients waiting for a bed in the units. He stated any type of diversion in the hospital affected the ED because when beds were closed, the patients remained in the ED for extended periods of time. In addition, critically ill patients were diverted to the Post Anesthesia Care Unit (PACU) backing up Post Surgery patients. A few months ago the slow turnaround for laboratory work was related to the layoffs but had improved somewhat. The Medical Director stated the physicians were very concerned for patient safety.

Interview with Physician #1, on 06/16/16, at 12:45 PM, revealed he had worked at the hospital for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 16	A 392		

forty (40) years and had never seen it this bad. He stated the layoffs of 2014 resulted in a massive turnover, in a short period of time, and included the loss of experienced nurses. "It created a different culture." He stated the ED was poorly staffed with this hospital having the highest volume of trauma patients and extremely high acuity patients. He stated ED and PACU staff were told there are no beds available; however, you could walk onto the units and beds were empty. Therefore, patients were being held in the ED and was a direct relation to not having enough staff to care for the patients. The physician stated it was not appropriate to keep critically ill patients in the ED for extended periods of time and it was unsafe. According to Physician #1, he had talked to leadership many times and with the culture of the present corporation, he did not see it getting better. He said he cared about patients and doing what was right.

Interview with Physician #3 (Program Director of Emergency Medicine), on 06/16/16 at 2:36 PM, revealed she had worked for the hospital for eleven (11) years and it had been a challenge with the amount of turnover in the nursing department. She voiced concern that so many experienced nurses had left and were replaced with unstable teams of contract nursing and new graduates. She stated Travel Nurses may be experienced but did not generally assimilate into this particular hospital's environment. She reflect the same concerns as the other physicians regarding the ED environment of high acuity, stressors, and high volume of patients. She revealed problems with long waits for labwork, even stat labs. Patients were being held in the ED for long periods of time because of no beds on the units. She said the ED was boarding ICU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 17	A 392		

patients and sometimes these patients required one to one nursing care which they could not receive in the ED. She stated trauma patients need nurses' time and other patients of less acuity have to wait. She stated the hospital was trying to recover from the layoffs. From a Program Director's view, the system was not working, and it had affected the Medical School Resident Program. The feedback received from the Residents' yearly survey revealed the Residents were frustrated because they could not get lab results, CT scans, and other test results timely. Comments on the surveys included the nursing staff shortage, patients spending nights in the ED, poor turn around in the ED, and not being able to admit patients timely to the units. The Program Director was concerned it could affect the Medical Resident's program and the School of Medicine may not attract the good candidates that could stay at the hospital and work in the community.

Interview with Physician #4, on 06/17/16 at 11:39 AM, and Physician #5, on 06/15/16 at 2:21 PM, revealed they had the same concerns as the other physicians.

Interview with RN #15, on 06/15/16 at 1:30 PM, revealed he had worked in the ED for eleven (11) years. He stated the ED Managers tried to keep the staffing ratio 4:1 (four patients to one nurse); however, they worked short often. He stated the more experienced nurses have left and there were a lot of new graduates and Travel Nurses taking their place. He stated the ED volume had increased and due to the staff shortage on the floor or units, beds were closed leaving the patients in the ED for extended periods of time. According RN #15, there were nineteen (19)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 18	A 392		

holds in the ED on 06/14/16 when he began his shift at 7:00 AM.

Interview with RN #3, on 06/14/16 at 7:40 PM, revealed the ED staffed according to peak times which was 11:00 AM-1:00 AM. He revealed the ED staff had worked short but had added Travel Nurses to assist. There were five (5) Travel Nurses of the eleven (11) staff scheduled for 06/14/16. He stated patients do have to wait longer depending on how busy the hospital was and the availability of opened beds. He could not say if the holds in ED were due to staff shortage on the units/floors.

A telephone interview with RN #2, on 06/17/16 at 9:25 AM and 5:57 PM, revealed she thought the hospital was not safe for the staff or patients. Many days the mixed units were staffed with no ancillary staff (Unit Secretary or Tech) to assist the nurse. On the rare occasion a Tech was scheduled, the Tech would be pulled as a sitter but the admission to the unit would continue. She stated the Patient Care Unit (PCU) was supposed to be staffed with three (3) nurses to one (1) patient and the mixed unit was suppose to be 5:1 ratio. She stated it was not uncommon to get back to back admissions after 7:00 PM, because they held the patients all day and then released the beds when the evening/night shift nurses were working. The nurse stated a few weeks ago the unit received ten (10) admissions in one hour. At about 7:30 PM, the ED would start calling before the nurses could receive report or conduct the first assessments of their patients. According to RN#2, there had been a shortage of beds and patients had been left on stretchers in the room. Recently when the hospital was on Diversion, patients were left on stretchers in the hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 19	A 392		

Last week (could not recall the specific date) the ED staff brought a patient up and placed them in the hallway because there were no beds available in the unit. She stated the acuity sheet had fifteen (15) patients listed; however, the computer had twenty (20). She stated patients were being transported to the unit without appropriate report. According to RN #2, patients with infections regarding isolation were being placed in semi-private rooms with other patients without infections because the nurse was not informed of the isolation precautions during report. She also revealed, equipment was not always available such as suction canisters, beds, IV poles and pumps, and the nurse would have to search for those items, taking time from the care of patients.

Interview with the Nurse Manager for five (5) South, on 06/20/16 at 9:30 AM, revealed the staffing ratio for this unit was 4:1 (four patients to one nurse). She stated only three (3) nurses were on the night shift, and they did not get another nurse. She stated the unit cared for very complex patients with new Tracheotomies, drains, tubes, IV's, and pain management. She stated this unit received back to back admissions from the Post-Acute Care Unit (PACU) with Monday and Wednesdays being the big surgery days. According to the manager, there were strict protocols for Post-OP care and walking the patients was included. She stated staffing was difficult, but the hospital had started giving incentives for nurses to pick up extra shifts. According to the Nurse Manager, she was working at the hospital when the layoffs occurred, and stated the hospital had not recovered.

Interview with RN #11, on 06/20/16 at 9:16 AM, revealed the staffing ratio was supposed to be 2:1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 20	A 392		

(two patients to one nurse); however, when she worked the night shift, usually there were only four (4) nurses. She stated she felt the staffing problem was getting worse instead of better. She was here during the layoffs and the hospital had lost a lot of experienced nurses. She validated the unit would close and not accept new admissions when there was not enough staff to care for the patients. Recently, she cared for a patient that had spent four (4) days in the ED but could not give any specific details.

She stated last week the unit received a trauma patient from the ED with multiple tubes, IV's, and intubated on the ventilator. This complex patient should have been a 1:1 ratio because the ET tube had to be replaced and the patient's oxygen saturation was low. In addition, a family member had a heart attack in the waiting room outside of the unit and the unit nurses had to respond. She stated patient's safety was at risk and the hospital's leadership was aware of the problem.

Interview with RN #13, on 06/20/16 at 11:45 AM, revealed she was a Travel Nurse with twelve (12) years of experience. She stated staff was pulled from this unit often leaving only four (4) nurses caring for ten (10) patients. She stated a ratio of 3:1 was not safe because nurses have to be off the unit for extended periods of time with their patients during procedures. According to RN #13, there was no transport service and nurses had to go everywhere with the patient . At night, radiology did not have any transport personnel. When there was a higher staffing ratio, the nurses do not have eyes on the patients. On 06/17/16, she was pulled to another unit with critically ill patients who were a safety issue with a staffing ratio of 4:1. She stated the ED dictated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 21	A 392		

when patients come to the unit. On several occasions the ED staff had brought patients up to the unit and left critically ill patients on a stretcher before the room had been cleaned. According to RN #13, the ED staff would leave the patient on the stretcher and "we have to try and care for a critical ill patient without the specialized equipment available in the ICU rooms. That is a patient safety risk."

Review of the staffing from June 17-19, 2016 revealed the ICU unit was staffed for 5:2, however, each day a nurse was pulled to another unit leaving four nurses to care for ten (10) patients. Continued review revealed, some nurses had taken three (3) critically ill patients.

Interview with RN #17, on 06/14/16 at 7:15 PM, revealed she worked on several different units throughout the hospital, and did not think the hospital was safe for patients. She revealed, frequently there was inadequate nursing staff. She often worked on 8 South (a mixed acuity PCU/Med-Surgical Unit), which had a lot of Stroke patients. Stroke patients often had physician orders for every one (1) hour assessments, blood pressure checks, and neurological checks. RN #17 stated it was impossible to complete the one (1) hour checks timely, and to manage four (4) other patients. In addition, she stated if she did not assess patients appropriately she could miss a change in condition which could lead to a negative patient outcome.

Interview with RN #18, on 06/14/16 at 7:40 PM, revealed she did not think there was adequate nursing staff to care for patients in a safe manner. She stated she frequently worked in the ICU and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 22	A 392		

often times had up to three (3) patients, and most of the time worked with no tech on duty. She stated the high acuity of the patients required frequent monitoring, including up to every one hour (1) assessments, blood glucose checks, and labs. She stated it was not possible to get everything done, and often patients were not turned every two (2) hours as ordered by the physician. RN #18 stated she often left work crying because she was fearful for her nursing license and for the well-being of the patient population.

Interview with RN #19, on 06/14/16 at 7:40 PM, revealed she worked on multiple units throughout the hospital and felt it was very unsafe. The nurse stated there were not enough nurses for true patient care, including not enough time to provide patient education, pass medications timely, or perform thorough patient assessments. She stated, in addition to the lack of nurses, there was also a lack of Techs. RN #19 stated often care such as bathing, and turning patients was omitted because tasks had to be prioritized and those were seen as less critical.

Interview with RN #22, on 06/14/16 at 8:10 PM, revealed she worked on multiple units throughout the hospital. She stated there were staffing issues throughout the hospital, specifically inadequate nursing staff. RN #22 stated when she worked in the ICU she typically had two (2) to three (3) patients, and often times there was no Tech on duty. On the PCU/Medical Surgical units she typically had five (5) to (6) patients and only one (1) Tech for up to twenty-five (25) patients. In addition, she stated medications were often administered late, she did not have enough time to properly assess patients, and patients were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 23	A 392		

getting turned in their beds or bathed at appropriate intervals. She recalled one instance where a patient laid soaked in urine for thirty (30) minutes because no other staff was available to assist her in cleaning the patient. RN #22 stated the hospital was not safe, inadequate staffing had compromised patient care, and it was only a matter of time before something bad happened.

Interview with RN #20, on 06/21/16 at 10:35 AM, revealed she felt the staffing on the unit was inadequate, and she often worked with five (5) nurses and one (1) Tech for twenty-five (25) patients. In addition, when there was only one (1) Tech on the floor, nurses had to obtain blood glucose checks, draw labs, and toilet residents on top of their other duties. For these reasons medications were often passed late, and dressing changes were not completed timely or had to be passed off for the next shift to complete. She stated this was a patient safety issue and an infection control concern.

Interview with Tech #1, on 06/21/16 at 10:00 AM, revealed she was concerned for patient safety on her unit. She stated on the weekends the unit was often staffed with only one (1) Tech for twenty-five (25) patients. In addition, Techs were often pulled to work on other units. She recalled an incident in April 2016 when she was the only Tech on duty and a patient's bed alarm sounded, she was unable to get to the patient because she was assisting with toileting for another patient at the time. She stated the nurses were busy, no one responded to the bed alarm and the patient fell. Tech #1 stated the incident could have been avoided if there had been more staff available to respond.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF LOUISVILLE HOSPITAL	530 SOUTH JACKSON STREET LOUISVILLE, KY 40202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
A 392	Continued From page 24 Interview with RN #21, on 06/21/16 at 2:10 PM, revealed the inadequate nurse staffing on the unit made it an unsafe environment for patients. RN #21 recalled an unsafe patient situation in April 2016. She stated four (4) nurses were on duty providing care for ten (10) patients, and the unit was not staffed with a Tech or Unit Secretary. RN #21 stated a patient went into distress and required resuscitation. All four (4) nurses were required to be with the patient to run the code and attempt to revive the patient. One nurse was needed to administer medications to the patient, one nurse was doing chest compressions, one nurse reported the situation to the physician, and one nurse obtained supplies. She stated no staff member was available to watch the other nine (9) patients. After the patient was stabilized, it was discovered that during the time the nurses were unavailable, another patient decannulated his/her tracheotomy. She stated this was a dangerous situation, as the patient could have gone into respiratory distress. In addition, RN #21 recalled another unsafe situation in January 2016. She stated four (4) nurses were on staff to care for ten (10) patients, with no Tech or Unit Secretary on duty. A patient went into cardiac arrest, all nursing staff were needed to attempt to revive the patient, and no one was available to watch the other nine (9) patients on the unit. During this time another patient extubated himself/herself. RN #21 stated luckily a Nurse Practitioner discovered the patient and was able to stabilize him/her. RN #21 stated this was an extremely dangerous situation which could have resulted in the patient going into respiratory distress and requiring resuscitation. RN #21 further stated it was only a matter of time before there was a negative patient outcome due to inadequate staffing.	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180141	A. BUILDING _____ B. WING _____	C 06/21/2016

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A 392	Continued From page 25	A 392		

Interview with the President of the hospital, on 06/15/16 at 10:55 AM, revealed he had worked at the hospital for over 20 years. He stated he was told to reduce the budget by 20% in February 2013 but was not given a dollar amount. He revealed sixty (60) full time positions were eliminated and the layoffs went by seniority. He said he attempted to cut services with the least amount of impact to the patients. He knew they would have to close some hospital beds related to short staffing. However, he did not close any programs. The reduction in the work force included nursing and ancillary staff like lab, Microbiology services, Phlebotomy, and Techs. Since the layoffs, the hospital had tried to rehire some staff but have not gotten back to the previous levels. After the layoffs, turnover of staff was very high, especially nursing. The nurses were willing to work extra to a certain point and then they became tired. He realized experienced nurses were leaving and during the survey of January 2016, the Accreditation Agency noted the lack of experienced nurses. According to the President, he had received multiple complaints from the physicians about the staffing, critical lab results not being delivered timely, and patients being held in the ED for extended periods of time. He stated he had worked hard to keep beds open and reviewed the discharge process of getting patients out of the hospital timely. He had met with the court representatives, Department of Community Based Services, and the Correctional Institutions to see if there was a faster way to get those patients assistance in the community so they can be discharged. This problem bottled-necked the beds. He identified problems with holding patients in the ED for extended periods of time because there were no beds

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A 392	Continued From page 26	A 392		

available in the units, and the case management team had worked on this with some improvement noted. He stated a culture of fear was created as a result of the layoffs and many experienced nurses left. The new Chief Nursing Officer (CNO) identified the nursing shortage and had implemented measures such as the utilization of Travel Nurses and new graduate nurses more than before. He validated the hospital had closed beds because there was not enough staff to care for the patients on the units. This had not occurred prior to the layoff. He stated the corporation was aware of the ripple effect of the layoffs.

Interview with Chief Medical Officer (CMO) on 06/15/16 at 10:08 AM revealed he had been the CMO since 2009 and had been at the hospital for twenty-nine (29) years. The CMO stated there had been big changes since the new corporation took over the management of the hospital. The biggest change was the new corporation looked at productivity (matching staffing to volume) and this was a big culture change for this hospital. In February 2014, there was a statewide layoff that affected this hospital. Beds were closed because there was not enough staff to care for the patients. Many of the experienced nurses left and that was when the physicians' starting voicing concerns. He stated the hospital had to be creative and that was when the Mixed Acuity Units were developed. In addition, the patients that had gone through Trauma Room were sometimes managed in the PACU. There were patients held in the ED for extended periods of time. He stated the hospital could decline outside transfers if there were not enough staff to handle that patient except for trauma patients. He stated the hospital tried to balance the workload and

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A 392	Continued From page 27	A 392		

tried not to be on diversion. However, the summer months are the busiest and high volumes of patients go through the ED with many requiring admission to the hospital. According to the CMO, there were good ideas floating around and the hospital was hiring within their restraints. He stated maintaining nursing staff was a problem.

Interview with the Chief Nursing Officer, on 06/15/16 at 10:20 AM, revealed she came to the hospital after the layoffs. She identified there was a staffing problem right away and had been working on the issues since. She validated there had been a large group of experienced nurses to leave the hospital for various reasons and the physicians were very concerned. She stated the ED staff were not part of the layoff but was affected by experienced nurses leaving. She implemented the Contract Travel Nurses, with commitment of three (3) months, and she had been actively recruiting new graduate nurses with bonuses and student loan assistance. This went into effect December 2015. However, this had not been effective for retention. The CNO revealed the staffing patterns for mixed units were 5:1 (five patients to one nurse) and could be 6:1 depending on the patient's acuity. The Critical Care Units have a ratio of 2:1 (two patients to one nurse) and could be higher at times. The Charge Nurse does take patients but not the Unit Managers. She stated the goal was to keep the nurse at the patient's bedside more. The Clinical teams round in the patient's room at bedside. The team would include nurses, Social Worker, pharmacy, and others. She stated maintaining a stable work force had been her priority for the last two years. She stated the nurses were younger and don't have the experience as the more

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A 392	Continued From page 28	A 392		

mature ones. She maintained dialogue with the nurses during her rounds and she validated they have complained about the staffing. According to the CNO, there were one hundred (100) nursing positions posted on this date. She monitored the staff turn-over through monthly dash board and shared that information during nursing leadership meetings.

Interview with the Chief Operation Officer (COO), on 06/17/16 at 8:54 AM, revealed she had been in that position for two (2) years. She came after the budget cuts and layoffs. She stated she knew coming to that position she would have many opportunities to improve. She said she conducted a weekly telephone conference with President to review all safety events. She would meet every other week with leadership. She revealed the Access Center was opened March 2016 and was staffed with Clinicians. This system had the capability of viewing all beds (statewide). She stated she was aware of the problems at this hospital. She stated the leaders were working on capital projects but had a long journey to recovery in where she wanted the hospital to be. She had spoken with several physicians and a representative from the School of Medicine to address their concerns about patient safety. According to the COO, she attended quarterly operation review meetings and had dialogue with chief quality officers. There had been a new re-structure of leadership staff. The goal was to have experienced nurses with comparative salaries to surrounding hospitals. She stated the corporation understood the problems and was aware beds were still being closed related to a lack of staff.

Interview with the Director of Patient Safety, on

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A 392	Continued From page 29 06/15/16 at 12:08 PM, revealed measurement of the time in ED for admission, time waiting for a room, and discharge was being monitored. It was included as a Core Measure and tracked and trended. The Director of the ED looked at real time and tracked monthly. She stated the ED trauma volume increased by 20% last year. She stated there had been increased time spent in the ED before admission to the unit related to no available beds in the units. Review of the Diversion list for June 2016 revealed the hospital was on full bed diversion from seven (7) to thirteen (13) hours on June 1, 13, 19, and 20, 2016. However, this list did not include the four beds closed in the ED on 06/10/16 because of short staffing.	A 392		