

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46206			
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S0000	<p>This visit was for one State hospital complaint investigation.</p> <p>Complaint Number: IN #00101155</p> <p>Substantiated: Deficiencies related to the allegations are cited.</p> <p>Date: 3-12-2012</p> <p>Facility Number: 005051</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/19/12</p>			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(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:</p> <p>(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.</p> <p>Based on medical record review and interview, the nurse executive failed to implement the facility's policy relating to assessment and documentation of</p>	S0912	<p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the</p>	06/25/2012			

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	<p>impaired skin integrity for 1 of 5 closed medical records reviewed (N1).</p> <p>Findings included:</p> <p>1. Facility policy, current in 2010 (last reviewed/revised May 2009), "Documentation Standards: Adults" provides in pertinent part on Page 9, Q, "SKIN ASSESSMENT 1. Documentation wound type, wound location, size, description, and any drainage at the site." and 3. "Assess and document every shift".</p> <p>2. On 2-18-2010 at 12:01 PM, non-intact skin was first identified and at 1 PM the following entry was made in N1's medical record regarding identification of left buttock skin breakdown of Stage 2 (area is reddened and open) " 2mm in diameter proshield [cream] applied and left open to air ". The next two skin assessments at 8:00 PM on 2-18-10 and at 8:00 AM on 2-19-2010 (prior to transfer on that date), lacked specific documentation of the size, description, and presence or absence of drainage of the impaired skin on N1's left buttock and documentation of care interventions, if any, implemented.</p> <p>3. During interview with S1 on 3-12-2012 at 4:30 PM , S1 indicated: a. confirmed the above findings in #1</p>		<p>statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law.</p> <p><u>Credible Allegation of Correction and Compliance:</u> For the purpose of any allegation that IU Health, Inc. is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health's credible allegation of correction and compliance.</p> <p>S 912 410 IAC 15-1.5-6 Nursing Service Corrective Action(s): The IU Health Methodist Hospital Manager of A6North reviewed the protocol SKPR 1.01 A, "Skin and Wound Care Protocol-Adult" to ensure the protocol met the required standards of practice. A plan was implemented to provide re-education/re-emphasis on the protocol expectations for each A6N Registered Nurse (RN). The objective of the plan was to ensure each A6N RN implemented the "Skin and Wound Care Protocol;" documenting the assessment and management of wounds each shift.</p> <p>Education: Beginning the week of June 25, 2012, mandatory education created by the Manager of A6N was provided to the nursing staff which included a review of the "Skin and Wound Care Protocol" with signed verification of understanding. RNs were instructed to document each shift: the skin assessment; including skin breakdown; the wound type; location;</p>				

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	<p>regarding N1's medical record.</p> <p>b. confirmed that the documentation of N1's impaired skin integrity following the initial identification assessment of 2-18-2010 at 12:01 PM was not in accordance with facility policy.</p>		<p>size; description; any drainage at the site; and care interventions performed by the nursing staff. Compliance with the above mentioned mandatory education has been included in the staff learning plan, and in orientation for new department hires. One-on-one re-education will occur with individual RNs if missing or incomplete documentation is detected during audits of patient records.</p> <p>Evidence of the above referenced education will be maintained within each staff member's personnel education file</p> <p>Monitoring: Beginning with care provided July 9, 2012; weekly audits will be conducted to determine if skin and wound assessments are completed, per protocol, with documentation in the patient's medical record. A minimum of 5 chart audits will be performed by the shift coordinator. Documentation audits will include:</p> <ol style="list-style-type: none"> the skin assessment including skin breakdown wound type location size description drainage at the site interventions performed <p>Sustainability: The audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If the required threshold is not met on random audit, consistent auditing will resume until such time that data for a</p>	

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			consecutive three months reflects achievement of 90% or greater compliance. Responsible Person: Weekly updates will be provided to Director of Clinical Operations: Medical Division.		

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S1318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on medical record review, document review, and interview, the facility failed to document that necessary medical information was included in telephone report or the transfer packet for 1 of 5 patient transfers reviewed.</p> <p>Findings included:</p> <p>1. Review of closed medical record of N1 indicated: a. N1 was admitted on 1-26-2010 and developed a Stage 2 skin ulcer first</p>	S1318	<p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. <u>Credible Allegation of Correction and Compliance</u>: For the purpose of any allegation that IU Health, Inc.</p>	06/25/2012			

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	<p>identified on 2-18-2010 while a patient on unit 6N.</p> <p>b. N1 was transferred to a rehabilitation facility on 2-19-2010.</p> <p>c. the medical record lacked documentation that the report phoned by the transferring RN to the receiving facility identified N1's impaired skin integrity as a follow-up care need.</p> <p>d. the medical record lacked documentation that the transfer packet prepared by the care coordinator contained information necessary to alert the receiving facility of N1's identified need for follow-up care regarding N1's skin ulcer.</p> <p>2. Facility policy "Documentation Standard: Adult" (last revised/revised May 2009), which applied to "all registered nurse, licensed practical nurses, student nurse externs, CNA's, and other employees who are responsible for documentation on forms and in the electronic medical record", provided in pertinent part: Page 13, V., 3. Discharge documentation, f. "Copy of the following chart documents must be sent with the patient when transferring to another facility... 2. d. Skin assessments (if skin not intact-Impaired Skin Integrity)".</p> <p>3. Facility policy "Care Management</p>		<p>is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health's credible allegation of correction and compliance. S 1318 410 IAC 15-1.5-10 Utilization Review & Discharge Planning Corrective Action(s):</p> <p>Nursing The IU Health Methodist Hospital Manager of A6North reviewed organizational policy NADM 1.30AP "Documentation Standards: Inpatient" to ensure the policy met the required standards of practice. A plan was implemented to provide re-education/re-emphasis on policy expectations to each A6N RN. The objective of the plan was to ensure each A6N RN completed and documented a "safe hand-off" to the receiving facility in the patient's medical record with care interventions provided. Education: Beginning the week of June 25, 2012, mandatory education created by the Manager of A6N was provided to the A6N nursing staff including a review of the NADM 1.30AP "Documentation Standards. Staff must ensure documentation of handoff information from the telephone report to the receiving facility and in the patient's transfer packet for the receiving facility. Compliance with the above mentioned mandatory education has been included in the staff learning plan, and is included in orientation for new department hires.</p>		

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	<p>Process", provided in pertinent part: Page 4, C. Discharge Plan, g. "CM utilize ECIN to make referral and communicate back and forth with potential post-acute care facilities and services. ... The referral includes: ... iii. Plan of care and service needs".</p> <p>3. During interview with S1 on 3-12-2012 at 4:30 PM , S1 indicated:</p> <p>a. confirmed the above findings in #1 above regarding N1's medical record.</p> <p>b. verified it could not be determined from N1's medical record that the phone report to the receiving facility addressed N1's follow-up care need regarding impaired skin integrity for an identified Stage 2 skin ulcer.</p> <p>c. indicated a record of the contents of the transfer packet from care coordination to the receiving facility were not/are not required to be maintained by care coordinators.</p> <p>d. verified it could not be determined from the medical record what medical information was included in the transfer packet.</p> <p>e. indicated the facility did not/does not have a policy which addressed/addresses the requirements for the care coordination transfer packets as to documentation of medical information sent to the receiving facility for transferred patients.</p>		<p>One-on-one re-education will occur with individual RN if missing or incomplete documentation is detected during audits of patient records. Evidence of the above referenced education will be maintained within each staff member's personnel education file for future reference. Monitoring: Beginning with care provided July 9, 2012, weekly audits will be conducted to ensure the patient's medical record contains nursing discharge documentation and a safe handoff note. A minimum of 5 chart audits per week will be performed by the shift coordinator. Audits will: 1. Review requirements to provide a safe handoff to the receiving facility. 2. Ensure the safe handoff information (impaired skin integrity) is provided to the receiving facility and is charted in the patient's medical record. Sustainability: Audits will begin July 9, 2012; the audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If the required threshold is not met on random audits, consistent auditing will resume until such time that data for a consecutive three months reflects achievement of 90% or greater compliance. Responsible Person: Weekly updates will be provided to Director of Clinical Operations:</p>		

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	4. During interview with S2 on 3-12-2012 at 4:45 PM , S2 confirmed N1's medical record lacked documentation of the content of the report from the transferring RN regarding N1's plan of care to include identification of a stage 2 skin ulcer of the buttock, care initiated, and ongoing need for assessment and skin care of N1's impaired/non-intact skin.		Medical Division. ----- ----- ----- Corrective Action(s):Care Management The IU Health Methodist Hospital Director of Integrated Care Management Services, the Case Manager Team Leader and the Integrated Care Management Education Coordinator reviewed organizational policies ADM 1.05 – “Integrated Care Management Documentation Process” and ICM 1.00 – “Care Management Process” to ensure these policies met the required standards of practice. A plan was implemented to provide re-education/re-emphasis on policy expectations to each Registered Nurse Care Manager (RNCM) and each Discharge Planning Social Worker (DPSW). The objective of the plan is to ensure the RNCMs and the DPSWs follow the Care Management Process and complete documentation in the patient’s medical record prior to discharging the patient. Education: Beginning the week of May 23, 2012, mandatory education, created by the Director of Integrated Care Management Services, the Team Leader and Education Coordinator, was provided to each RNCM and DPSW. Education included a review of policies governing hospital guidelines on documentation in the medical record. Compliance with the		

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			<p>above mentioned mandatory education has been included in the staff learning plan, and is included in orientation for department hires. One-on-one re-education will occur with individual RNCM and DPSW if missing or incomplete documentation is detected during audits of patient records. Evidence of the above referenced education will be maintained within each staff member's personnel education file for future reference. Monitoring: Beginning with care provided May 23, 2012; weekly audits of 5 charts per week have been conducted to assess for the completeness of documentation including: a. Date/time of note. b. Discharge date. c. Discharge disposition: home, home with home care, outpatient services, community resources, skilled nursing care, etc. d. If a facility placement, the name of the facility, location and contact information will be documented as well as the level of care the patient is to receive there. e. Transportation arrangements including vendor name, contact name/number, and date/time of the pick-up f. Confirmation of the plan with the patient/family/multidisciplinary team, including name of family member and contact number when applicable. g. Choice Letter and Medicare IM Letter given if applicable. h. The patient's discharge disposition. i.</p>	

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			<p>Signature/pager number. Additionally, Care Management will audit 5 charts per week to ensure that RNCMs and DPSWs are utilizing the ECIN (Extended Care Information Network) to make referrals and communicate with the receiving facility. At the time of transfer, the staff will review the communication with the facility and document the summary of information sent to the receiving facility.</p> <p>Documentation will include: a. Patient demographics b. Diagnosis c. Plan of care and service needs d. Patient location e. Name of insurance company f. Projected discharge date g. Date and time of delivery of services / products h. DME provider with prescription, if required. Sustainability: The audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If the required threshold is not met on random audit, consistent auditing will resume until such time that data for a consecutive three months reflects achievement of 90% or greater compliance. Responsible Person: The Team Leader will be responsible for ensuring that the audits and compliance verifications are complete. Monthly updates will be provided to the Director, the Coordinator, and the Executive Director of</p>	

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			Integrated Care Management.	