

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150173	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 5165 MCCARTY LN LAFAYETTE, IN 47905
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S 0000 Bldg. 00	<p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00171948 Substantiated: State deficiency related to the allegation is cited.</p> <p>Facility Number: 011506</p> <p>Survey Date: 07/20/2015</p> <p>QA: cjl 07/31/15</p>	S 0000		
S 0932 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review and interview, the facility failed to to ensure all patients had an individualized plan of care for 1 of 5 patients reviewed (#3).</p>	S 0932	Responsible Person: Lorraine Brown, Administrative Director for Inpatient Services"The RN review of Patient Plan of Care (PPOC) has been added as a distinct	09/01/2015

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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	<p>Findings included:</p> <p>1. The facility policy "Routine Adult Inpatient Nursing Assessment, Care Planning, and Documentation Standard Practice Guidelines", effective June 2014, indicated, "B. Nursing plans for patient care based upon assessing the patient's total nursing care needs; not just those related to the admitting diagnosis. C. The Patient Plan of Care (PPOC) is kept current by ongoing assessment of the patient's needs and response to interventions; and updated and revised in response to assessment. ... E. The Patient Plan of Care is based on the RN assessment and addresses the physical, emotional, social and educational needs of the patient and family."</p> <p>2. Medical record #3 indicated the patient was brought by ambulance to the ED (emergency department) at 1052 hours on 04/19/15 after being found unresponsive at home. The EMS (Emergency Medical Service) staff indicated the patient's blood sugar was 29 and they administered glucagon by injection. Upon arrival at the ED, the patient was somewhat confused, but was able to drink oral glucose, then eat some food. At 1127 hours, the patient's glucose was rechecked and was 125. The</p>		<p>element of the Bedside Handoff Standard Work of bedside handoff (see attached). The work will include review and modification of the plan at the time of shift change (or other times of care transition from one nurse to the other)to reflect any changes in priority or problems. The validation and auditing of the work will be incorporated into the standard work of unit managers, who will dedicate a 2 hour block of time every weekday morning from 9-11 to rounding on patients, staff, and validating standard work elements.</p>	

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	<p>patient was admitted to the facility and seen by the cardiologist who noted some confusion and paranoia and indicated some anxiolytic medication might be helpful to keep the patient calm so that he/she would be cooperative with medication management of his/her conditions.</p> <p>At 1551 hours on 04/19/15, nursing documentation indicated the patient was confused, combative, and not following directions, and the hospitalist, MD2, was called. A one-time order for Haldol 0.5 mg. (milligrams) IV (intravenous) was received and given to the patient. At 1600 hours, nursing documentation indicated the Haldol was given, but the patient took the saline flush, broke it, and indicated he/she did not want any more medication. MD2 was notified and contacted another hospitalist, MD4, who came to the unit to see the patient. At 1630 hours, nursing documentation indicated the patient had pulled out his/her catheter, but was calmer now.</p> <p>A Safety and Security report from 1729 hours on 04/19/15 indicated staff was called twice to the patient's room to help calm him/her down. Nursing documentation from 2100 hours on 04/19/15 indicated the patient refused to let the nurse recheck the blood sugar.</p> <p>The care plan listed the following problems: ineffective coping, fall risk,</p>			

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	<p>unstable glucose, ineffective respirations, alteration in skin, and alteration in nutrition. There was no problem of confusion or agitation and no interventions dealing with these issues.</p> <p>At 0726 on 04/20/15, MD2 saw the patient and indicated he/she was uncooperative and agitated. The physician was called later that morning because of the patient's agitation and ordered a dose of Ativan 0.5 mg. IV at 1004 hours which resulted in some improvement of the agitation.</p> <p>Another Safety and Security report from 1317 hours on 04/20/15 indicated they had been called by nursing staff who indicated the patient had been acting strangely and had placed a butter knife under his/her leg. Nursing indicated the patient had not threatened anyone, but they were concerned because of the behavioral swings. The security staff indicated they were able to talk to the patient, assist him/her out of bed to stretch his/her legs, and remove the knife.</p> <p>3. At 3:35 PM on 07/20/15, staff member #9, the RN Shift Coordinator, reviewed the electronic medical record for patient #3 and confirmed there was no issue on the care plan dealing with the confusion, agitation, and combativeness that was exhibited by the patient. He/she also confirmed there was no</p>			

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	documentation regarding any family communication regarding how to deal with these issues.				