

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
(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	
S000000	<p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00123684 Substantiated: State deficiency related to the allegations is cited.</p> <p>Facility Number: 005002</p> <p>Survey Date: 10/03/2013</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/17/13</p>	S000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402
---	---

(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
S000422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
(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	
	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013	
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402			
(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			
	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on medical record review, policy and procedure review, administrative document review, and interview, the facility failed to report a hospital acquired stage III pressure ulcer for 1 of 5 patients (#P1).</p> <p>Findings included:</p> <p>1. The medical record for patient #P1 indicated an Emergency Department (ED) admission on 01/07/13 due to an accidental fall at home which resulted in a left distal femur fracture. The admitting nursing assessment indicated the patient was a medium skin breakdown risk, and did not have any skin breakdown, rashes, or discolorations. Skin assessments were all documented as within normal limits until 2245 on 01/10/13 when a floor nurse described a sacral decubitus, stage III, 4 x 7.5 x 0.2, and indicated it was not pre-existing. The record lacked any further documentation of this until 01/15/13 when the wound care nurse, staff member N4, performed an assessment and indicated, "Patient has a suspected DTI (deep tissue injury) that was not documented upon admission." Staff member #N4 indicated the area measured 4 cm. (centimeters) by 3.5 cm.,</p>	S000422	<p>Actions Taken: The Stage III hospital acquired wound identified in the survey was reported through the state's on-line reporting system, State Health Gateway. Responsible Person: Director, Regulatory and Corporate Compliance Status: Complete Prevent Recurrence: As referenced in the Statement of Deficiencies, the Hospital's policy, "Management of Sentinel Events, Adverse Events, and Unusual Occurrences," requires reporting of all stage III/IV hospital acquired pressure ulcers that do not meet exclusion criteria. To ensure all HAPU's are reported according to policy and regulation, the Hospital's internal communication process was clarified. All responsible parties were educated on the expectations below: 1) The wound nurses use a standardized form to document any hospital acquired wound, regardless of stage, identified during daily rounds. 2) Once complete, the wound nurse sends the form to the Unit Manager, Unit Director, Director of Nursing Quality, and Risk Management. 3) Risk Management verifies the completion of a risk report. 4) Director of Nursing Quality immediately informs the Director of Regulatory and Corporate Compliance of any stage III/IV</p>	10/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013	
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402			
(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			
	<p>was clean, dry, intact, blanchable, with erythema (redness) and was not open. The next assessment by the wound care nurse was on 01/21/13 and indicated, "Patient had a suspected DTI that has now opened to a stage III." The wound measurements were 4 cm. x 7.5 cm. x 0.2 cm. with a scant amount of serous drainage.</p> <p>A note by MD1 on 01/23/13 indicated, "Stage II decubitus ulcer on the sacrum 1.5 x 1.5 inches in diameter. A consult by the wound care physician, MD2, on 01/23/13 indicated, "Patient has a sacral decub, stage III. It is not severe with no significant depth." The patient was discharged on 01/29/13 and the discharge summary by MD1, dictated 02/05/13, listed "Pressure ulcer, stage III" as one of the diagnoses.</p> <p>2. The facility policy "Management of Sentinel Events, Adverse Events, and Unusual Occurrences", last reviewed 12/10, indicated, "This policy provides the process for managing and reporting sentinel events, adverse events and unusual occurrences. ...4. Care Management Events: ...f. Stage 3 or 4 pressure ulcers acquired after admission to the hospital. Excludes progression from stage 2 to 3 if the stage 2 or stage 3 pressure ulcer was recognized upon admission or was unstageable because of</p>		<p>hospital acquired pressure ulcers that should be reported to the state.5) The Director of Regulatory and Corporate Compliance reports to the state using the on-line reporting system (State Health Gateway) no later than fifteen (15) working days after the adverse event is determined to have occurred.Responsible Person for Oversight: Director, Nursing QualityStatus: Initiated 10/16/13, ongoing The wound nurses submit a monthly report to the Director of Nursing Quality with all pressure ulcer patients consulted and seen. The report includes the wound staging and whether the wound was present on-admission or hospital acquired. The Director of Nursing Quality confirms all reportable events were communicated to the Director, Regulatory and Corporate compliance for state reporting.Responsible Person for Oversight: Director, Nursing QualityStatus: Initiated 10/16/13, ongoing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402
---	---

(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
	<p>the presence of eschar. The policy continued, "Regulatory Specialist: Reporting: ...ISDH Adverse Events: Reportable ISDH adverse events are outlined in the definitions section of this policy. The report shall be electronically submitted to ISDH no later than fifteen (15) working days after the reportable event is determined to have occurred."</p> <p>3. Administrative documentation indicated a Risk Control Data Review, created 01/11/13 at 1221, which indicated, "Patient has Stage I decubitus/bruising area to coccyx" from 10:30 PM on 01/10/13. The form continued, "Risk Management Addendum: On 1/15/13, nursing writes: Patient has a suspected DTI to the sacrum that is a HAPU [hospital acquired pressure ulcer]."</p> <p>4. At 12:50 PM on 10/03/13, the wound care nurse, staff member #N4, was interviewed by phone. He/she indicated patient #P1 had a deep tissue injury when assessed on 01/15/13 and did not have a stage III decubitus ulcer as documented by the staff nurse on 01/10/13. However, he/she indicated this area had progressed to a stage III pressure ulcer when he/she did the next assessment on 01/21/13. He/she also confirmed a hospital acquired stage III pressure ulcer was a reportable</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402
---	---

(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
	<p>event, but that was not his/her responsibility, but was the physician's.</p> <p>5. At 1:10 PM on 10/03/13, staff member #N1 indicated the wound care nurse was not certified in January, at the time of the event, and was not officially credentialed to stage the skin area as far as determining whether or not it would be classified as a reportable event. He/she indicated the facility did not have any reportable events for the first quarter of 2013.</p> <p>6. At 2:25 PM on 10/03/13, the Corporate Compliance Officer, staff member #N5, was interviewed by phone and indicated he/she would be notified when there was the possibility of a reportable event and it would then be his/her responsibility to do the actual reporting. He/she confirmed the facility had no reportables for the first quarter of 2013.</p> <p>7. At 2:30 PM on 10/03/13, staff member #N1 indicated that since the wound care nurse was not certified to stage the wound on patient #P1, the physician's determination would be the official diagnosis. The admitting physician first documented the wound as a stage II, but classified it as a stage III in the discharge summary. MD2, who was called in for a wound consult, also classified the wound</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
(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	
	<p>as a stage III. After review of the medical record, staff member #N1 acknowledged this event qualified as a reportable event.</p> <p>8. At 3:30 PM on 10/03/13, staff members #N1, N2, and N7 confirmed the hospital acquired pressure ulcer on patient #P1 qualified as a reportable event and it could not be determined why this was not done.</p>				