

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
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S000000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 8-13-13</p> <p>Facility number: 009443</p> <p>Complaint number: IN00130285 Substantiated; Related deficiencies cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 09/25/13</p>	S000000		
S000420	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the hospital: (A) The following surgical events: (i) Surgery performed on the wrong body</p>			

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>part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p>			

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	<p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient;</p>			

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	<p>(DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p>			

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	<p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and staff interview, the facility failed to report a stage IV pressure ulcer acquired after admission to its facility for 1 of 5 patients (patient #1).</p>	S000420	By October 11, 2013, the Director of Quality (DQM) and the Chief Nursing Officer (CNO) will re-educate all of the Leadership team and all clinical employees on policy # R03A	10/18/2013

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	<p>Findings:</p> <p>1. Review of patient #1 medical record indicated the following:</p> <p>(A) The patient was admitted to the facility (ICU) on 5/10/12 from an acute care hospital due to ventilator dependant respiratory failure.</p> <p>(B) Nursing narrative notes dated 5/11/12 at 0740 indicated a skin assessment was completed and there was no indication that the patient had an area or deep tissue injury on the left or right ischium.</p> <p>(C) Admission photos were taken on 5/11/12 by the wound care staff and indicated the patients gluteal area had a rash type area. A photo taken on 5/18/12 by a wound care nurse revealed the rash area healed. The photo had the patients left ischium area evident and there was not an abnormality noted.</p> <p>(D) The patient was documented as having an "unstageable" area on the left ischium measuring 5.0 x 3.8 on 6/6/12. The area was documented as having slough and eschar. Additionally, the patient was documented as having a stage II area on the right ischium measuring 1.0 x 2.8 on the same date. The areas were documented as pressure areas. The wound on the left ischium was documented as developing into a stage IV</p>		<p>RISK MANAGEMENT regarding completing an incident report on all Stage 3 or 4 pressure ulcers acquired after admission to the hospital. Confirmation of this education is maintained in the employee's education file and reported at the OIC/MEC/GB committee. To ensure future compliance of this regulation is met, the DQM will monitor all documentation and incident reports related to hospital acquired pressure ulcers. 100% of all Stage 3 and Stage 4 HAPUs will be reported to the ISDH. The compliance reporting rate will also be reported at the monthly Leadership/QAPI meeting and then quarterly to the OIC/MEC/GB committees using the following formula: denominator is the number of Stage 3 and 4 HAPUs and the numerator is the number of Stage 3 and 4 HAPUs reported to ISDH.</p>	

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	<p>area on 7/11/12.</p> <p>(E) Photos were taken and the areas described in (D) were documented by staff member #4 (a wound care nurse) The document did not indicate that a deep tissue injury had been present in the left ischium prior to the development of the unstageable wound that progressed to a stage IV pressure area.</p> <p>(F) There was no evidence in the patients H&P, wound care nursing assessments, nursing assessments, physician consultations x 3 that the patient had a deep tissue injury to the left ischium on admission. Additionally, a progress note written by the dietician on 5/30/12 indicated the patients skin was intact. The dietary progress notes dated 6/8/12 indicated the patient had "new" wounds to right and left ischium.</p> <p>2. Staff member #4 (wound care nurse involved with patient #1) indicated the following in interview beginning at 12:00 p.m. on 8/13/13:</p> <p>(A) He/she does not believe that patient #1 had a deep tissue injury on admission. He/she took pictures of the patient and saw the area that developed into a stage IV wound.</p> <p>(B) The medical record for patient #1 had no documentation that the patient had a deep tissue injury upon admission to the facility.</p>						

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	<p>3. Staff member #1 indicated the following in interview beginning at 1:00 p.m. on 8/13/13: (A) There were no reportables to the ISDH for patients #1-5. It was determined by corporate and the physician that patient #1 had a deep tissue injury on admission that developed into a stage IV wound, therefore it was not reported. (B) The medical record for patient #1 had no documentation that the patient had a deep tissue injury upon admission to the facility.</p> <p>5. Staff member #3 indicated the following in interview beginning at 5:15 p.m. on 8/13/13: (A) The medical record for patient #1 had no documentation that the patient had a deep tissue injury upon admission to the facility.</p> <p>6. The facility has a policy in place for reportable events titled "RISK MANAGEMENT: Significant Patient Injury/Unanticipated outcomes" last reviewed/revised 10/10. The policy states on an addendum page "This process will also be followed if a reportable event, as recognized by the Indiana State Department of Health Medical Error Reporting System (1)</p>			

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S000912	<p>should occur." The policy gave clear directions on reporting.</p> <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</p>			

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	<p>nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and staff interview, the facility failed to ensure the nurse executive established standards of nursing care related to pressure ulcer identification and wound care treatment orders for 1 of 5 patients (patient #1).</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record indicated the following:</p> <p>(A) The patient admitted to the facility (ICU) on 5/10/12 from an acute care hospital due to ventilator dependant respiratory failure.</p> <p>(B) Nursing narrative notes dated 5/11/12 at 0740 indicated a skin assessment was completed and there was no indication that the patient had an area or deep tissue injury on the left or right ischium.</p> <p>(D) Admission photos were taken on 5/11/12 by the wound care staff and indicated the patients gluteal area had a rash type area. A photo taken on 5/18/12 by a wound care nurse and revealed the rash area healed. The photo had the patients left ischium area evident and there was not an abnormality noted.</p> <p>(E) The patient was documented as having an "unstageable" area on the left</p>	S000912	<p>100% of nurses will be re-educated by the Chief Nursing Officer (CNO) on policy WC III-27 "Wound Documentation" and S05-G "Guidelines and Protocols" relating to treatment and wound care orders being document in the medical record. Training will be completed by the Chief Nursing Officer (CNO) or designee on October 18, 2013 during the clinical staff meeting. Confirmation of this education is maintained in the employee's education file and reported at the OIC/MEC/GB committee. To ensure that treatments are administered per order, 60 medical records that have treatment orders will be audited by the CNO and DQM until 4 months of data averages a 90% compliance rate. Compliance results are reported to the OIC/MEC/GB committee using the following formula: the denominator is the number of wound care treatment orders and the numerator is the number of treaments carried out that were congruent to orders.</p>	10/18/2013

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	<p>ischium measuring 5.0 x 3.8 on 6/6/12. The area was documented as having slough and eschar. The wound had not been identified as a staged wound prior to the development of an unstageable wound. Additionally, the patient was documented as developing a stage II area on the right ischium measuring 1.0 x 2.8 on the same date. The areas were documented as pressure areas. The wound on the left ischium was documented as developing into a stage IV area on 7/11/12.</p> <p>(F) The record lacked evidence that orders for wound care were followed. The patient had an order written 6/6/12 for Skin Prep, Triad coloplast wound ointment, foam adhesive to the left ischium to be completed daily and prn. The record lacked documentation that the treatment was completed on 6/15/12, 6/16/12, 6/18/12, 6/29/12, 7/5/12, 7/7/12, and 7/8/12.</p> <p>(G) The patient had an order written 7/9/12 for Skin prep, Allenderm to open areas, EPC to surrounding area to be completed twice daily and as needed to the right ischium. The record lacked documentation that the treatment was completed twice on 7/11/12 or completed at all on 7/15/12 and 7/16/12.</p> <p>2. Staff member #4 (wound care nurse involved with patient #1) indicated the</p>			

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	<p>following in interview beginning at 12:00 p.m. on 8/13/13:</p> <p>(A) The medical record for patient #1 had no documentation that the patient had a deep tissue injury to the ischium upon admission to the facility.</p> <p>3. Staff member #1 indicated the following in interview beginning at 1:00 p.m. on 8/13/13:</p> <p>(A) The medical record for patient #1 had no documentation that the patient had a deep tissue injury upon admission to the facility.</p> <p>(B) He/she verified in email dated 8/16/13 that the wound care orders were not followed for patient #1 as indicated above.</p> <p>4. Staff member #3 indicated the following in interview beginning at 5:15 p.m. on 8/13/13:</p> <p>(A) The medical record for patient #1 had no documentation that the patient had a deep tissue injury upon admission to the facility.</p>			