

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152021	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/07/2012
NAME OF PROVIDER OR SUPPLIER  ST VINCENT SETON SPECIALTY HOSPITAL LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HARTFORD ST LAFAYETTE, IN 47904		
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S0000	<p>This visit was for a State hospital complaint investigation.</p> <p>Complaint: #IN00106835 Substantiated: State deficiency related to the allegations is cited.</p> <p>Facility Number: 003495</p> <p>Survey Dates: 06/07/2012</p> <p>Surveyor: Sandra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/28/12</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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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on medical record review, policy and procedure review, and interview, the registered nurse failed to ensure orders for wound care were followed for 4 of 5 patients (#N1, N2, N3, and N4) and failed to ensure 3 of 5 patients (#N1, N3, and N4) were turned as required per policy.</p> <p>Findings included:</p> <p>1. The medical record for patient #N1, admitted 02/29/12 with acute respiratory failure with ventilator support, a tracheostomy and subarachnoid hemorrhage indicated the following:</p> <p>A. An initial nursing assessment indicated the patient had a colostomy, a slightly reddened tube feeding site, Duoderm on the coccyx, and a reddened, edematous penis.</p> <p>B. An Initial Wound/Ostomy/Continence Assessment from 03/02/12 indicated a coccyx wound of 5 centimeters (cm) by 4.5 cm. with Santyl with foam border to be changed daily, an open area under the flange of the trach with Replicare applied</p>	S0930	<p>All bedside associates educated on the expectation of turning and reposition patient's every 2 hours and the proper documentation of such in the patient's medical record. Education was provided during daily huddles beginning June 8, 2012 and reinforced as part of their annual performance review. Complete date: July 20, 2012 In addition, nursing associates were educated on expectation and proper documentation of skin assessments, treatments, and MARs. Education was provided during daily huddle beginning June 8, 2012 and reinforced as part of their annual performance review. The wound care team are also rounding with nursing and providing additional 1 on 1 education, as needed. Complete date: July 20, 2012 In addition, wound care associates were educated on the importance of timely assessments and reassessments based on patient's needs. Education with wound care associates was provided 1 on 1 by the Site Administrator/CNO during the</p>	07/20/2012	

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	<p>and covered with 4 x 4 gauze, and Aquacel AG ordered around the tube feeding site. Other orders from the assessment included routine colostomy care, turning every 2 hours, and a low air loss mattress.</p> <p>C. The Skin and Wound Care Treatment Record for the week of 03/14/12 for the trach/clavicle wound indicated a new order from 03/16/12, "Flush with Normal Saline, apply Bacitracin, then gauze to cover and pad, RT (respiratory therapist) to change three times a day and as needed for soilage". The form lacked documentation of the treatment being done on 03/18/12, 03/19/12, and 03/20/12.</p> <p>D. The Skin and Wound Care Treatment Record for the week of 03/07/12 for the coccyx wound indicated orders from 03/02/12, "1. Cleanse with normal saline 2. Apply Santyl to wound bed 3. Cover with foam border. Frequency- change daily". The form lacked documentation of the treatment being done on 03/09/12, 03/10/12, and 03/11/12. The Treatment Record for the week of 03/21/12 indicated the same orders and an additional order, "Gently pack with normal saline moist gauze and change daily", but lacked documentation for 03/25/12, 03/28/12, and 03/29/12.</p> <p>E. The Skin and Wound Care Treatment Record for the week of 03/07/12 for the</p>		<p>month of June 2012. Complete date: June 30, 2012. There has also been a small interdisciplinary taskforce assigned to review the wound care and nursing documentation forms and make recommendations for additional improvements. Taskforce started in July 2012. Upon taskforce completion and recommended changes to documentation forms an audit will be implemented to monitor proper documentation/form completion and compliance with new process. There will also be a follow-up communication via Patient Care Services (PCS) Staff Meeting Minutes and Post-Test to assure that everyone has received and understands this information. The PCS minutes and post test will be distributed to staff during the month of July 2012. The Site Administrator/CNO is the responsible party.</p>				

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	<p>penile wound indicated orders from 03/06/12, "1. Clean with normal saline 2. Apply Xeroform gauze, frequency-change daily and as needed for soilage". The form lacked documentation of the treatment being done on 03/09/12, 03/10/10, 03/11/12, 03/12/12, 03/15/12, 03/18/12, 03/21/12, and 03/25/12.</p> <p>F. The Skin and Wound Care Treatment Record for the week of 03/02/12 for the tube feeding skin area indicated orders from 03/02/12, "1. Cleanse with normal saline 2. Apply Aquacel AG around peg site and cover with drain sponge. Frequency- change daily". The form lacked documentation of the treatment being done on 03/05/12, 03/09/12, 03/10/12, 03/11/12, 03/12/12, 03/18/12, 03/22/12, 03/25/12, 03/26/12, 03/28/12, 03/29/12, and 04/01/12.</p> <p>G. The Care/Assessment Flow Sheets lacked documentation of every 2 hour position change as indicated by the following notations: left side at 2000 and 2200 on 02/29/12, right side at 2400 and 0200 and omissions at 0400 and 0600 on 03/01/12, an omission at 1500, back position at 1900, 2000, and 2200 on 03/10/12, back position at 0800, 1000, 1600, 1800 on 03/31/12, and back position at 0400 and 0600 on 04/01/12..</p> <p>2. The medical record for patient #N2, admitted 02/07/12 with renal failure and</p>				

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	<p>multiple diagnoses, including decubitus ulcers, indicated the following:</p> <p>A. An Initial Wound/Ostomy/Continence Assessment from 02/08/12 indicated, "...6. Bilateral knees: clean with normal saline, apply a liberal amount of silver med. gel and cover with Mepilex foam, change every other day. 7. Bilateral feet eschars: Paint with betadine. Right foot weekly. Left foot, daily, then wrap with Kerlex".</p> <p>B. The Skin and Wound Care Treatment Record for the week of 02/15/12 lacked documentation of the treatment being done on 02/15/12 and 02/20/12.</p> <p>3. The medical record for patient #N3, admitted 02/21/12 with numerous diagnoses and complications of treatment indicated the following:</p> <p>A. An Initial Wound/Ostomy/Continence Assessment from 02/22/12 indicated the patient should be turned every 2 hours and, "...6. Cover sacral wounds with Mepilex. Change as needed for soilage. ...Suspected DTI (deep tissue injury) not yet completely demarcated. Will watch closely and change treatment plan as necessary". The record lacked any further documentation regarding this DTI.</p> <p>B. The Care/Assessment Flow Sheet from 02/29/12 lacked documentation of turning the patient between 0900 and 1500 and indicated the back position at</p>			

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	<p>2100 and 2300. The sheet from 03/01/12 indicated back position again at 0100 and right side at 0300 and 0500. The sheet from 03/02/12 indicated back position at 0800, 1000, and 1200 and no documentation for 1600.</p> <p>4. The medical record for patient #N4, admitted 03/27/12 with a diagnosis of respiratory system problems with ventilator support indicated the following: A. An Initial Wound/Ostomy/Continence Assessment from 03/28/12 indicated the patient had wound vacs due to slow healing bypass graft sites and the treatments would be done 3 times a week by the wound team. The patient was to be turned every 2 hours and was placed on a low air loss mattress. The wound evaluation indicated 7 specific wound sites. B. The Care/Assessment Flow Sheet from 04/01/12 indicated back position at 2200 and 2400. The sheet from 04/02/12 indicated back at 0200, 0400, 0600, and 0700. Both sheets lacked documentation of assessments of the 7 wounds in the section designated for this information.</p> <p>5. The facility policy "Positioning Patient in Bed: Lying on Back or Side", approved 03/2011, indicated, "...If the patient's primary activity is bedrest and/or the patient must be assisted or is dependent</p>			

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	<p>upon assistance to move, position must be changed at least every two (2) hours".</p> <p>6. The facility policy "Viewing: Nursing Assessment and Reassessment", approved 03/2011, indicated under Reassessment, "A. Minimal Nursing Reassessment: In order to evaluate the patient's response to care, a nursing 'head-to-toe' reassessment occurs at least twice per shift or more frequently as determined by practice standards and with any significant changes in the patient's status or diagnosis. The 'head-to-toe' reassessment for inpatients includes the following minimal information: ...5. Status of skin and all invasive lines, catheters, wounds, drains, etc."</p> <p>7. The facility policy "Standard of Care: Skin Breakdown: Actual- Management of Adult Patient With", approved 02/2011, indicated, "...All patients with actual skin breakdown require documentation in the narrative notes. The Wound Ostomy Contenance Nurse or designee is available for consultation." The policy continued under Evaluation/Monitoring, "Reassess with each dressing change or immediately if evidence of deterioration is indicated by increase in exudate and wound edema, loss of granulation tissue, purulent discharge and/or odor (document assessments, interventions and outcomes</p>						

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	<p>an appropriate chart forms)."</p> <p>8. At 5:30 PM on 06/07/12, the site administrator, staff member #A1, confirmed the medical record findings and acknowledged the lack of documentation for all of the wound care and skin assessments. He/she agreed that the wound care nurse indicating patient #N3 would need to be watched closely, but not documenting any further on the DTI, was not the standard of practice and documentation should have been done weekly.</p>			