

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150150	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825
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S000000	<p>This visit was for the investigation of a State complaint.</p> <p>Complaint Number: IN 00150114</p> <p>Substantiated: deficiencies cited related to the allegations</p> <p>Date: 7-02-14</p> <p>Facility Number: 002408</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: cloughlin 07/10/14</p>	S000000		
S000930	<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 upon document review, medical record (MR) review and interview, the nurse executive failed to ensure that the</p>	S000930	<p>S-0930</p> <p>1. All Medical/Surgical nurses and techs have been re-educated on</p>	08/01/2014

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>standards of care were maintained and the policy/procedure for medical record documentation was followed for 1 of 5 medical records (patient 27) reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Documentation by Health Care Providers (approved 10-13) indicated the following: "The care must be documented by any and all providers of care ...[and] ...each department will document items that are relevant to clinical practice ..." The MR for patient 27 failed to indicate on 5-23 and 5-24-14 that a bath was provided to the patient and failed to indicate on 5-23-14 that the patient's bed linen was changed. During an interview on 7-02-14 at 1430 hours, patient care tech A6 indicated that all of the medical-surgical patients receive a daily bath and indicated that the bed linen is changed daily. The tech A6 indicated that a computer may not be available to document the bath and bed linen change at the time of service. During an interview on 7-02-14 at 1650 hours, chief nursing officer A1 and chief quality officer A2 confirmed that the MR for patient 27 lacked 		<p>the "Documentation by Health Care Providers" Policy. Re-education included timely documentation of baths and bed linen changes. Education was completed on August 1st, 2014.</p> <ol style="list-style-type: none"> Documentation of baths and linen changes will be audited on a monthly basis for six months and on-going until compliance is maintained for at least three consecutive months. Thirty Medical/Surgical medical records will be audited monthly for bath and linen change documentation. Compliance rates will be tracked on departmental quality report cards. Compliance rates will be reviewed quarterly at the Hospital's "Operation Performance Team" meetings. One on one re-education with progressive disciplinary action, up to and including termination will be imposed for team members who fail to follow the Documentation policy. The Medical Services Team Leader is ultimately responsible for items 1 and 2 above. Date of Completion is August 1st, 2014. 	

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S001318	<p>documentation indicating that a bath was provided on 5-23 and 5-24 to the patient and lacked documentation indicating on 5-23 that the patient's bed linen was changed.</p> <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 Based upon document review, medical</p>	S001318	S-1318 1. All Medical/Surgical nurses	08/01/2014

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	<p>record review and interview, the facility failed to follow its policy/procedures and ensure that patient discharge instructions included the discharge instruction to contact the surgeon or attending physician for questions, concerns or symptoms regarding the surgery or hospital stay (fever, change in pain or sensation, bleeding or drainage, etc) for 5 of 5 (patients 23, 24, 25, 26 and 27) medical records (MR) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Discharge Planning (approved 2-13) indicated the following: "Physician initiates the medical discharge and participates in discharge planning by ensuring all necessary orders, medical instructions, and prescriptions are completed. Medical follow-up appointments are addressed and discharge information is shared with the guest (or patient) ...[and] ...each health care professional involved in a guest's discharge should document in the guest (or patient) record according to professional standards and hospital guidelines."</p> <p>2. On 7-02-14 at 1255 hours, chief nursing officer A1 indicated that they (A1) was advised that A10, an unidentified rounding</p>		<p>have been re-educated on the "Discharging an Adult Guest from the Hospital" Policy. Education was completed on August 1st, 2014. The template discharge instructions for adult guests were modified to include indication of when to call or follow-up with the physician. The adult discharge instructions now include the following: Call your physician if:</p> <ul style="list-style-type: none"> · You have new onset or changes in pain · You have a temperature over 101 degrees F · You experience increased swelling · You have incisional redness, bleeding, or drainage · You have numbness or tingling of legs (not present on admission) · You have any other worrisome condition <p>In the event of a medical emergency such as difficulty breathing/swallowing or severe bleeding, please go to the nearest Emergency Room or call 911. The discharge instructions were revised on July 29th, 2014. The above information will now automatically print on all adult discharge instructions for patients. All Medical/Surgical nurses were educated on providing problem related education to every patient prior to discharge. Problem specific education has been obtained and is now available for nurses to provide</p>	

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	<p>practice group nurse for the surgeon recalled that patient 27 required re-instruction at the time of discharge. The chief nursing officer A1 was requested to provide documentation of any physician practice group discharge instructions provided to patient 27 on 5-24-14 and no documentation was provided prior to exit.</p> <p>3. During an interview on 7-02-14 at 1645 hours, chief clinical officer A1 confirmed that no documentation of discharge instructions provided to patient 27 on 5-24-14 by a physician practice group nurse around the time of discharge was available.</p> <p>4. The policy/procedure Discharging an Adult Guest from the Hospital (approved 3-14) indicated the following: "Physician will provide discharge orders (education) and prescriptions including controlled substances for the nurse to give the guest (or patient) ...the nurse will then ...educate guest about discharge instructions ...and follow-up care (including answering any questions related to guest's care) ...[and] ...provide guests with copies of instructions and prescriptions."</p> <p>5. The MR discharge instructions for patients 23, 24, 25, 26 and 27 lacked</p>		<p>to each patient.</p> <p>2. Discharge Instructions will be audited on a monthly basis for six months and on-going until compliance is maintained for at least three consecutive months. Thirty Medical/Surgical medical records will be audited monthly to ensure patients received problem specific education and education as to when to call their physician after discharge. Compliance rates will be tracked on departmental quality report cards. Compliance rates will be reviewed quarterly at the Hospital's "Operation Performance Team" meetings. One on one re-education with progressive disciplinary action, up to and including termination will be imposed for team members who fail to follow the Discharging an Adult Guest from the Hospital policy.</p> <p>3. The Medical Services Team Leader is ultimately responsible for items 1 and 2 above.</p> <p>4. Date of completion is August 1st, 2014.</p>		

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	<p>documentation of follow-up care needs after surgery.</p> <p>6. The MR discharge instructions for patient 27 indicated that no problem related patient education materials were charted as provided.</p> <p>7. During an interview on 7-02-14 at 1710 hours, the chief nursing officer A1 and the chief quality officer A2 confirmed that the MR for patients 23, 24, 25, 26 and 27 lacked documentation of follow-up care needs after surgery.</p>			