STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	1007 LINCOLNWAY LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0000	This visit was for 4 hospital complaint investigations. Complaint: #IN00095074 Unsubstantiated - lack of sufficient evidence. #IN00090096 Unsubstantiated - lack of sufficient evidence #IN00090040 Substantiated - State deficiencies related to the allegations are cited #IN00086095 Unsubstantiated - lack of sufficient evidence Survey Date: 01/10/12 Facility #: 005006 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor QA: claughlin 02/17/12	S0000	Comments are noted. Please see S 0930 and S 0946 for our response.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the facility failed to assure the supervision of care provided to each patient in 1 of 6 medical records reviewed. Findings include: 1. Review of the medical record for P#5 daily nursing documentation indicates the patient was given a daily bed bath and morning and evening care and turned/positioned every 2 hours. On 4/16/11 it was documented "fentanyl 25 mcg topical patch to upper right chest wall removed dated 4/9/11 disposed of." The physician was contacted and notified of the patch and an order was received from the physician to remove and discontinue use of fentanyl patch. There was no order for a fentanyl patch in the record for this patient. No documentation was found that indicated the fentanyl patch was found during the admission skin assessment, daily baths, or during surgery.	S0930	On 2/10/12, an action plan was initiated based on the survey exit information. This initial action plan included investigating the feasibility of utilizing the Electronic Medical Record to aid in addressing fentanyl patches applied at home, and to formulate an education plan for nursing staff regarding procedures for addressing the patches and for performing and documenting complete skin assessments. On 2/22/12 nursing, quality and clinical informatics leadership met to finalize and implement the following items as a result of receiving additional survey information:#1. An order and task are being added to the Electronic Admission Care Set to serve as a reminder for the registered nurse to assess the patient for any medication patches or devices and to continue or discontinue it per the physician order. The Director of Clinical Informatics is overseeing this implementation which will be completed by 3/16/12.#2. RN education is occurring to remind nurses to ask patients upon admit	02/10/2012

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	2. On 1/10/12 at 2:00 PM interview with N#5 remembers medication error with patient who had a fentanyl patch on that was discovered after the patient had been in the hospital for several days. The patient had been to surgery, and had been bathed daily, no one found the patch until the day a different aide was giving the patient a bath and the aide found the patch. This aide questioned the nurse about when the patch was due to be removed and the nurse removed the patch, called the physician and received an order for the patch to be removed. There was a report on this incident. 3. No documentation was available to indicate an appropriate resolution to this medication error was determined and put into place to assure this error does not happen again.		about the existence of any patches that were applied at home. The Unit Directors will provide the education to their staff by 3/31/12. Education is also being provided for the CNA's to notify the nurse of any existing patches that are not dated or are out-of-date. The Unit Directors will provide the education by 3/31/12. Monitoring for the effectiveness of the above action plan items will be performed by the nursing unit directors or their designees by a random sampling audit of charts, determined by a report of patients admitted with fentanyl patches from home. The audit will look for compliance with documentation and administration of continued patches and compliance with documentation of removal for discontinued patches. This monitoring will occur on a monthly basis beginning 4/1/12 for a period of 3 months. A compliance rate of less than 90% will require continued monitoring until a 90% compliance rate is achieved. Results will be reported by the nursing unit directors to the Nursing Standards and Quality Committee for review and any follow up action. #3. Nursing leaders will be educated on documentation of event report follow-up to include appropriate resolutions put into place to assure the event does not happen again. The Risk Management Coordinator will	

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			provide the education and monitor through the event reporting system for any issues related to patches and will report through the quarterly event reporting process. This monitoring will begin with the first quarter 2012 reporting to occur in April, 2012 and will continue for the reporting of all four quarters of 2012.	

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S0946	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4) (c) Drugs and biologicals shall be prepared for administration and administered as follows: (4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.			
	Based on document review and interview, the facility failed to assure that medications were administered in accordance with an order of a physician in one of six medical records reviewed. Findings include: 1. Review of the medical record for P#5 daily nursing documentation indicates the patient was given a daily bed bath and morning and evening care and turned/positioned every 2 hours. On 4/16/11 it was documented "fentanyl 25 mcg topical patch to upper right chest wall removed dated 4/9/11 disposed of." The physician was contacted and notified of the patch and an order was received from the physician to remove and discontinue use of fentanyl patch. There was no order for a fentanyl patch in the	S0946	On 2/10/12, an action plan was initiated based on the survey exit information. This initial action plan included investigating the feasibility of utilizing the Electronic Medical Record to aid in addressing fentanyl patches applied at home, and to formulate an education plan for nursing staff regarding procedures for addressing the patches and for performing and documenting complete skin assessments. On 2/22/12 nursing, quality and clinical informatics leadership met to finalize and implement the following items as a result of receiving additional survey information:#1. An order and task are being added to the Electronic Admission Care Set to serve as a reminder for the registered nurse to assess the patient for any medication patches or devices and to continue or discontinue it per the	02/10/2012

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	record for this patient. 2. On 1/10/12 at 2:00 PM interview with N#5 remembers medication error with patient who had a fentanyl patch on that was discovered after the patient had been in the hospital for several days. The patient had been to surgery, and had been bathed daily, no one found the patch until the day a different aide was giving the patient a bath and the aide found the patch. This aide questioned the nurse about when the patch was due to be removed and the nurse removed the patch, called the physician and received an order for the patch to be removed. There was a report on this incident. 3. No documentation was found that indicated the previous aide(s) or nurses caring for P#5 were re-educated or counseled about the missed fentanyl patch.		physician order. The Director of Clinical Informatics is overseeing this implementation which will be completed by 3/16/12.#2. RN education is occurring to remind nurses to ask patients upon admit about the existence of any patches that were applied at home. The Unit Directors will provide the education to their staff by 3/31/12 Education is also being provided for the CNA's to notify the nurse of any existing patches that are not dated or are out-of-date. The Unit Directors will provide the education by 3/31/12.#3. RN education is occurring to remind nurses to ask patients upon admit about the existence of any patches that were applied at home. The Unit Directors will provide the education to their staff by 3/31/12. Education is also being provided for the CNA's to notify the nurse of any existing patches that are not dated or are out-of-date. The Unit Directors will provide the education by 3/31/12. Monitoring for the effectiveness of the above action plan items will be performed by the nursing unit directors or their designees by a random sampling audit of charts, determined by a report of patients admitted with fentanyl patches from home. The audit will look for compliance with documentation and administration of continued patches and compliance with documentation of removal for discontinued	

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			patches. This monitoring will occur on a monthly basis beginning 4/1/12 for a period of 3 months. A compliance rate of less than 90% will require continued monitoring until a 90% compliance rate is achieved. Results will be reported by the nursing unit directors to the Nursing Standards and Quality Committee for review and any follow up action.	