

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2014
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
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S000000	<p>This visit was for investigation of three State hospital complaints.</p> <p>Facility Number: 004972</p> <p>Complaint Numbers: IN00135493: Substantiated: no deficiencies cited</p> <p>IN00139356: Unsubstantiated: Allegation did not occur</p> <p>IN00140118: Substantiated: deficiencies cited related and unrelated to the allegations</p> <p>Date: 5/27/14 and 5/28/14</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: clauglin 06/18/14</p>	S000000	<p>July 2, 2014</p> <p>John Lee, RN, MBA Nurse Surveyor Supervisor Program Director, Hospitals ASCs Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Dear Mr. Lee:</p> <p>Please find enclosed the plan of correction for the complaint investigation that was conducted by the Indiana State Department of Health on May 28, 2014 at the Indianapolis Campus.</p> <p>We appreciate the opportunity to improve the quality of our services.</p> <p>If you have any questions or concerns, please feel free to contact me at (317) 528-8378.</p> <p>Sincerely,</p> <p>Shelley D. Voelz, RN, BSN, CPHQ, FNAHQ Director Standards Compliance</p>	
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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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S000912	<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 nursing care and practice in all settings in which nursing care is</p>		<p>and Patient Safety</p> <p>Enclosures</p> <p>SDV:lw</p>	

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	<p>provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the nurse executive failed to ensure the implementation of the facility policy related to nursing care plans, for 3 of 5 patients (pts. #11, #12, and #14).</p> <p>Findings:</p> <p>1. Review of the policy and procedure " Plan of Care ", policy number 400.15, with an initial approval date of 2/8/11, indicated:</p> <p>a. On page one under " Purpose ", it reads: " ...It is the expectation that each patient will have a comprehensive, integrated, multidisciplinary plan of care, which is developed from the initial patient assessment... " .</p> <p>b. On page three under " Plan of Care " , in section " V. General Statements: " , it reads: " ...B. The RN (registered nurse) is responsible for initiating a nursing plan of care within 8 hours from the time of admission... " .</p> <p>c. On page three under " Plan of Care " , in section " VI. Procedure: " , it reads: " A. Initiating the Nursing Plan of Care...3. Develop the plan of care (must be initiated within eight (8) hours of admission)... " .</p> <p>2. Review of patient medical records indicated:</p>	S000912	<p>1a. Review the Patient Care Coordinator (PCC) Quality Rounding sheet weekly. The PCC Quality Rounding sheets are completed daily by the PCC. Plan of Care (POC) is a measure on the rounding sheet that the PCC audits for compliance of POC. PCC will remind staff to complete the POC if not done.</p> <p>1b. Utilize EPIC our electronic medical record system to identify a POC on admission – specifically adding the Care Plan Last documented feature and the RN Overview tabs for quick review. The AICU leadership will review this daily during rounds. Staff will be reminded to complete the POC if not done.</p> <p>1c. Will need to educate the AICU leadership team on these action steps to assure accountability.</p> <p>1d. Will add POC metric to the FSFH Quality AICU Dashboard for compliance.</p> <p>1e. Will conduct unit huddles (manager/PCC) informing staff of compliance with policy/POC #400.15. In addition will be shared with staff in staff meetings week of July 7, 2014.</p> <p>Responsible Persons: AICU manager, director, patient care</p>	07/07/2014

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S000932	<p>a. Pt. #11 was admitted at 6:39 PM on 10/10/13 to the CCU (critical care unit), died at 5:45 AM on 10/11/13, and had no nursing care plan initiated.</p> <p>b. Pt. #12 was admitted at 10:52 AM on 11/14/13, died at 2:20 PM on 11/15/13, and had no nursing care plan initiated.</p> <p>c. Pt. #14 was admitted on 11/5/13 at 10:49 AM and the nursing care plan was first noted in the medical record on 11/6/13.</p> <p>3. Interview with staff member #57, the RN Clinical Informatics Specialist, at 11:20 AM on 5/28/14, indicated:</p> <p>a. No nursing care plan could be found in the medical record for patient #11 who was hospitalized more than 8 hours prior to their death.</p> <p>b. No nursing care plan could be found in the medical record for patient #12 who was hospitalized for more than 24 hours prior to their death.</p> <p>c. The nursing care plan for patient #14 was noted to have been initiated about 20 hours after admission.</p> <p>d. Nursing staff failed to follow the nursing care plan policy in regards to patients #11, #12, and #14.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p>		<p>coordinator (PCC), and clinical educator (CE).</p> <p>1a. Ongoing – initiated 6/30/14. The quality rounding form exists but will add the measure for POC.</p> <p>1b. Ongoing – initiated the week of 6/30/14.</p> <p>1c. Will be completed by 7/7/14.</p> <p>1d. Beginning July, 2014, will audit the AICU quality rounding tools for compliance.</p> <p>1e. Beginning 7/1/14 huddles will occur throughout the week and week of 7/7/14 at staff meetings.</p> <p>1f. FFSH Quality Dashboard submitted to executive leadership on a quarterly basis.</p>				

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	<p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on patient medical record review, and staff interview, the nursing executive failed to ensure that one registered nurse (N7) followed practitioner orders, per standards of practice, in one instance.</p> <p>Findings:</p> <p>1. Review of the medical record for patient #12 indicated:</p> <p>a. An order was written at 1:55 PM on 11/15/13 for prn (as needed) Fentanyl 25 to 50 mcg every 15 minutes.</p> <p>b. RN (registered nurse) N7 gave 50 mcg of Fentanyl to this patient at 1:57 PM on 11/15/13 and again at 2:10 PM on 11/15/13.</p> <p>2. Interview with staff member #58, the ICU (intensive care unit) Director and supervisor of RN N7, at 11:25 AM on 5/28/14, indicated:</p> <p>a. Staff member N7 gave a second dose of Fentanyl 13 minutes after the first dose, for pt. #12.</p> <p>b. The order for Fentanyl was every 15 minutes.</p> <p>c. Nurse N7 failed to follow physician</p>	S000932	<p>2a. In the July AICU staff meeting staff will be provided education on the policies related to administration and documentation of analgesics.</p> <p>2b. FSFH has a Pain Committee and there are two AICU staff members who are representatives. The staff members audit the number of patient charts as determined by the Pain Committee. This is a minimum of 20 charts every two months.</p> <p>2c. Pain metrics of assessment, documentation will be added to the FSFH AICU Quality dashboard.</p> <p>Responsible Persons: AICU manager, director, patient care coordinator (PCC), and clinical educator (CE).</p> <p>2a. Education provided to staff by the two AICU RN Pain</p>	07/14/2014

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	orders by giving the Fentanyl early. d. The nurse also failed to document the need for the two doses of prn Fentanyl given to pt. #12.		representatives by July 14, 2014. 2b. Ongoing. 2c. FSFH Quality Dashboard submitted to executive leadership on a quarterly basis.		