

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
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S000000	<p>This was an investigation for two State hospital complaints.</p> <p>Complaint: #IN00124342 Substantiated: State deficiency related to the allegations is cited.</p> <p>#IN00129541 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 005002</p> <p>Survey Date: 12/10/2013</p> <p>Surveyor: Sandra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/20/13</p>	S000000			

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 provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, administrative document review, and interview, the facility failed to ensure measures were implemented to prevent skin breakdown</p>	S000912	Corrective Actions: Educational "Need to Know" sent out to Patient Care Leadership on required wound care intervention documentation and requirement for all patients to be up in the	01/07/2014			

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	<p>for 2 of 2 patients (N1 and N4).</p> <p>Findings included:</p> <p>1. The medical record for patient N1 indicated an admission to the facility on 01/27/12 due to a seizure/syncope episode with altered mental status. Nursing documentation indicated the patient's skin was within normal limits upon admission. The Braden skin risk assessment was documented as 14 which indicated the patient should have been turned every 2 hours and activity should have been encouraged and increased. The medical record indicated the patient was not repositioned/turned 7 times on 02/01/12, 9 times on 02/02/12, 12 times on 02/03/12, 7 times on 02/04/12 and 6 times on 02/06/12. Nursing documentation indicated the patient was on bedrest the entire hospitalization, but the record lacked a physician order for this. The first documentation of any skin problems was at 2210 on 02/05/12, by nursing staff member A5, who called for a wound consult due to 2 spots on buttocks area. At 1644 on 02/06/12, the wound care nurse, staff member A4, performed an initial assessment indicating there was a stage 2 decubitus on the sacrum that measured 3.3 cm. (centimeters) by 2.1 cm. with a depth of 0.1 cm. and with a</p>		<p>chair at least daily unless there's an order for bed rest (Attachment A).Responsible Person: Director, Nursing QualityCompletion Date: 1/7/14 Unit Managers to review "Need to Know" and re-educate all inpatient nursing staff on wound care interventions and required documentation during January 2014 Unit Meetings. Education documented in meeting minutes. Education must reach 100% of inpatient nursing staff.Responsible Person: Unit ManagersCompletion Date: 1/31/14 Nursing Education to create on-line tutorial on documentation of Q2 hour turning in the electronic medical record, including documentation required when patient is not turned for a reason (off unit, etc.). Education will include screen shots of the electronic medical record. HealthStream on-line training will be assigned to all Nursing.Responsible Person: Director, Nursing EducationCompletion Date: HealthStream assigned to Nursing by 1/30/14, 100% Nursing to complete by 3/31/14 Monitoring:Daily Cares/Turn Schedule report developed by IT for daily auditing of documentation of turning (Attachment B).Responsible Person: Manager, ITCompletion Date: 1/3/14 Nurse Managers/Directors to run report daily to verify completion of</p>				

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	<p>scant amount of serous drainage. A hydrocolloid dressing was applied with directions to change every 3-4 days. The patient was discharged to a long term care facility the next day.</p> <p>2. The medical record for patient N4 indicated an 78 year old admitted on 12/04/13 for dehydration, renal insufficiency, and urinary tract infection. Documentation indicated the Braden score was 13 on 12/05/13 and 9 on 12/06/13 which would necessitate assistance from staff for turning and repositioning. Documentation of every 2 hour repositioning was missed for 5 times on 12/05/13 and for 4 times on 12/06/13.</p> <p>3. The facility policy "Pressure Ulcer Assessment and Management Protocol", last revised 07/13, indicated, "Perform a head-to-toe skin assessment upon admission and daily thereafter for patients identified to have wounds and/or pressure ulcers. ...Assess each patient's ongoing risk for further pressure ulcer formation by using the Braden Scale- upon admission, every day thereafter by the AM shift. ...If a patient's score is 14 or below, Wound Care Consult is to be ordered. ...Positioning and Pressure Relieving Interventions: Turn and reposition the</p>		<p>wound care documentation for 30 days. 100% of inpatients to be monitored. Documentation failures will be monitored by Nurse Managers and Directors and reported to the Chief Nurse Officer. Nurse Managers/Directors to talk directly with nurses involved with failed documentation identified in audits. For non-compliance, re-educate nurses on the required wound care documentation, including turning and repositioning patients. Nurses who do not improve compliance will receive corrective action. Responsible Person: Nurse Managers/Directors Completion Date: Begin 2/3/14 Nursing Mangers to document compliance on audit tool (Attachment C). Managers to submit completed audit tool to Nursing Directors every Monday. Responsible Person: Nurse Managers Completion Date: Begin 2/10/14 Nursing Directors to compile audit results from Units and send to Director, Nursing Quality every Friday. Responsible Person: Nurse Directors Completion Date: Begin 2/14/14 Data: 100% review will continue until 3/10/14. If compliance is less than 95%, monitoring will continue for an additional 30 days until compliance is met. Once compliance is met at < 95%, monitoring will continue using sampling methodology for an</p>		

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	<p>patient at least every two hours using a turning/repositioning schedule." The Braden Risk Assessment, which was an attachment to the policy, indicated, "Moderate Risk 13-14: ...Minimize pressure: encourage increased mobility and activity, ...turn and reposition patient every 2 hours."</p> <p>4. At 3:45 PM on 12/10/13, staff member A2 provided a document titled "HAPU Action Plan", dated October 01, 2013, which outlined various actions and changes to be implemented as a result of wounds not being correctly identified, timely skin assessments upon admission, and inconsistent skin breakdown interventions employed. The time frames progressed through July 2013 with education of all staff, addition of "Skin Champions", new processes for wound care consults, new processes with 2 nurses performing admission skin assessments, and hiring a second wound care nurse. The problem of turning every 2 hours with chimes was to be ensured with twice a week direct observation on all 3 shifts and was documented as "10/01/13- Process in place and continued validation planned. 11/06/13- Audit shows compliance."</p> <p>5. At 4:00 PM on 12/10/13, staff member A1 provided a document titled</p>		additional 60 days (to end as early as 6/6/14).		

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	<p>"Bedside shift report evaluations" which was a summary of a unit manager's observations the week of 12/02/13. Two of the five observations indicated the skin was not checked for breakdown and another one indicated there was no patient assessment at all.</p> <p>6. A "Turning Observation Audit" summary was sent to the surveyor on 12/11/13 by staff member A1 which indicated direct observations were conducted between 06/01/13 through 08/03/13 and were 100% compliant except for one week on one unit that had 10% noncompliance. The document indicated "Audits formally ceased end of August".</p> <p>7. At 4:10 PM on 12/10/13, staff member A2 indicated problems with skin issues were identified around the end of 2012 or beginning of 2013, and as a result, an action plan was instituted in May of 2013. He/she indicated all of the nurses were reeducated, a second wound care nurse was hired, skin rounds were conducted weekly with the wound care nurse along with staff nurses, and two nurses now perform the initial skin assessments on new admissions. Monitoring of all of the new interventions continue to prevent any further problems.</p>						

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	<p>8. At 4:25 PM on 12/10/13, staff member A1 talked with the director of quality, staff member A8, by phone, who indicated the ongoing monitoring was now informal with no review of the charting documentation.</p> <p>9. At 4:45 PM on 12/10/13, all three staff members A1, A2, and A3 confirmed the medical record findings and acknowledged there were still problems with documentation and implementation of all of the action plan items. They also confirmed there was no physician order for bedrest for patient N1.</p>				