

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150021	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845
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S 0000 Bldg. 00	<p>This visit was for the investigation of one State hospital complaint.</p> <p>Complaint Number: IN00200210: Substantiated, deficiency related to allegations is cited. Deficiencies unrelated to allegations are cited.</p> <p>Date of Survey: 6/7/16 and 6/8/16</p> <p>Facility Number: 005020</p> <p>QA: cjl 06/13/16</p> <p>IDR Committee held on 07-27-16. Tag S0868 modified. JL</p>	S 0000	<p>Parkview disputes this substantiation because the allegation was not supported by staff interviews, the event report, and the documentation in the electronic medical record. Parkview understands the allegation was there was bruising to the patient's face as a result of a fall, but the patient was admitted with injuries from a fall at home. The patient did not sustain any new injuries from the fall that occurred while the patient was cared for in the hospital. There is also no evidence that the fall was covered up. It was thoroughly reviewed as per Parkview's protocol. Therefore, Parkview disputes the substantiation of the allegation. Please see the skin assessment which was done upon admission.</p>	
S 0758 Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(9)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(9) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.</p>			

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>Based on document review and interview, the medical records department failed to ensure the implementation of the consent for treatment policy for one of 6 closed medical records, patient #1, and for 1 of 4 open medical records reviewed, patient #8.</p> <p>Findings Include:</p> <p>1. Review of the policy: Consent for Treatment, no policy number, last approved on 4/15/2014, indicated in the "Policy Statement" area: "Under Indiana law, a patient must provide Informed Consent to the healthcare provided to him/her...Parkview Health complies with the requirement of Indiana law and with the standards of accrediting agencies relating to consent for treatment." On page 3 in the section: "IV. General Consent For Treatment A.", it reads: "Consent by a Competent Adult Patient or Emancipated Minor - If a patient is over 18 years old or is an Emancipated Minor, the patient must consent to his or her own Health Care, unless a physician has determined and has documented in the medical record that the patient is not competent to make his or her own Health Care decisions...".</p> <p>2. Review of closed and open medical records indicated:</p>	S 0758	<p>1.How are you goingto correct the deficiency? Response: Registration staff are assigned on each work shift to go to the inpatient unit to follow upon missing authorization to treat signatures that have fallen into a work queue in Epic. If the registration staff are unable to obtain the signature from the patient or family member at that time, they contact the nurse leader for the unit to ask registration to be notified when the patient or family member is able to sign. Registration staff will continue to follow up on each shift until the signature is obtained. Each time they are unable to obtain the signature, a note will be placed on the patient's account, and the account will be deferred in the work queue for continued follow up until resolution. Registration will also revise the current alert sheet that is sent with the unsigned authorization to treat form to the unit upon admission to include the contact number for the registration staff to be notified once the patient is able to sign or family is available to assist with a signature. All registration staff will be re-educated on this process. Information on this revised process will be shared with nursing leadership to inform their clinical staff. 2. How are you going to prevent the deficiency from recurring in the future? Response: Random</p>	08/01/2016			

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	<p>A. Patient #1 was admitted on 4/29/16 and discharged on 5/4/16 with no consent for admission and treatment in the medical record.</p> <p>B. Patient #8 was a current patient admitted to the MICU (medical intensive care unit) on 6/4/16 who had no consent for admission and treatment in the medical record.</p> <p>3. At 1:40 PM on 6/8/16, phone interview with staff member #58, the director of patient access, confirmed that neither patient #1, nor #8 had signed consents for admission and treatment in their medical record, and that:</p> <p>A. Patient #1 had notes that registration attempted twice to get the consent signed while the patient was in the ED (emergency department), but no follow up was done after that.</p> <p>B. After review of the current medical record for Patient #8, it was determined that there has been no consent for admission and treatment signed even though the patient or family member(s) have signed for various procedures during this hospital stay.</p> <p>C. If registration does not get an authorization for admission and treatment prior to admission to a nursing unit, the paper form is to be sent to/given to the medical unit staff so that they can get the consent signed. This was not done for</p>		<p>audits of at least ten patient charts from all nursing units will be completed by the Patient Access Managers in conjunction with Quality Management monthly. 3. Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc.? Response: The Patient Access Managers at Parkview Regional Medical Center and Parkview Randalia hospitals are responsible for correcting the deficiency. The Director of Patient Access is responsible for reviewing the audit results and for providing any additional follow up. 4. By what date are you going to have the deficiency correct? Response: All re-education will be completed by 8/1/2016 Random chart audits will begin 8/2/16 Registration alert sheet will be revised by 8/30/2016</p>	

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S 0868 Bldg. 00	<p>patients #1 and #8.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review and interview, the medical staff failed to ensure the implementation of its rules and regulations regarding the attending/sponsoring physician visits for 1 of 3 MICU (medical intensive care unit) medical records (Patient #2).</p> <p>Findings Include: 1. Review of the medical staff rules and regulations, last approved 3/8/16, indicated in section "II. Rules Affecting</p>	S 0868	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Response: All Critical Care Physicians and Allied Health Professionals (AHP) have been educated that all ICU patient records must reflect notes regarding the daily visit by the physician. Compliance audits were established. The accountability process was defined. 2. Describe how the facility reviewed all clients in the facility that could be affected by</p>	07/01/2016

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	<p>All Medical Staff", in item E. "Patient Visit by Advanced Allied Health Practitioners in Place of Physician Daily Visit:...2. The attending/sponsoring physician sponsoring the Advanced AHP (allied health practitioner) must visit the patient at a minimum of every other day and is responsible for the initial visit and admitting History and Physical examination."</p> <p>2. Review of three MICU medical records indicated Patient #2 was admitted to the MICU on 4/29/16 and had no physician progress notes for the remainder of their stay on that unit. The patient was moved to the 6th floor med/surg unit on 5/5/16.</p> <p>3. At 4:14 PM on 6/8/16, interview with quality and accreditation staff members #50 and #59 confirmed that after a phone call with the medical staff services staff, #61 and #62: With only AHP progress notes for the 6 days Patient #2 was in the MICU, the rules and regulations were not followed as a physician was to see patients at least every other day, per the rules and regulations, and there is no documentation to show that this occurred.</p>		<p>the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Response: All patients in all ICU's are seen by a physician each day. 100% of AHP notes are audited to ensure that a physician has also documented their daily visit. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Response: All Critical Care Physicians and Allied Health Professionals (AHP) were educated on July 14, 2016 regarding the by laws requirement that all ICU patient records must reflect notes regarding the daily visit by the physician. On July 01, 2016the Practice Manager established an audit process to assess compliance. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Response: The Practice Manager audits 100% of medical records of patients seen by AHP's to ensure that a physician has also documented their daily visit. Audits will continue until compliance rate of 100% is achieved for Three (3) consecutive months. Any/all</p>	

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S 0912 Bldg. 00	<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>		issues identified by the audits will be forwarded to the Critical Care Specialty Representative for peer review following the Medical Staff Quality Plan.	

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	<p>Based on document review and interview, the nursing executive failed to ensure the fall policy was implemented for 6 of 6 patients who encountered falls while hospitalized at the facility, patients #1, #2, #3, #4, #5 and #6.</p> <p>Findings Include:</p> <p>1. Review of the policy: Fall Prevention - Adult and Peds, no policy number, last approved 10/2015 indicated on page 3., in section F. Interventions initiated based on Fall Risk assessment score as follows: 1. Low Fall Risk: A Fall Risk score of 0 - 24...Follow Standard fall precautions...2. Moderate Fall Risk: A Fall Risk score of 25 through 44...Implement additional interventions per hospital policy (see hospital addendum). 3. High Fall Risk: A Fall Risk score of 45 or greater...(see hospital addendum)...".</p> <p>2. Review of the facility addendum, page 13, indicated for "MODERATE Fall Risk: Score 25 - 44...2. Interventions: Follow Standard Fall precautions plus additional required interventions as indicated below: Initiate High Risk for Fall Care Plan Yellow wristband on patient Implement hourly fall prevention checks:...Toileting: Do not leave patient unattended during toileting. Stay within line of sight and arms reach while patient</p>	S 0912	<p>1.How are you going to correct the deficiency? Response: Nursing staff will be educated at the July 2016 staff meeting on leaving patients on bed-pans unattended, completion of the post fall flow sheet, the fall risk criteria for use of bed alarms, hourly rounding expectations, and assisting patients who are on fall precautions. The EMR problem with populating the "alarm on" section of the fall intervention was fixed June 08, 2016.</p> <p>2.How are you going to prevent the deficiency from recurring in the future? Response: All falls will be audited for policy compliance and completing the post fall flowsheet until three (3) consecutive months with 90% compliance.</p> <p>3.Who is going to be responsible for numbers 1 and 2 above; i.e. director, supervisor, etc? Response: Chief Nursing Executive for Parkview Health System.</p> <p>4.By what date are you going to have the deficiency correct? Response: Education will be completed for all nursing staff in July 2016. Audits will begin August 01,2016.</p>	08/01/2016

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	<p>is using toilet, on bed pan, on bedside commode...Use of bed/chair alarm...HIGH Fall Risk: Score of [equal to or greater than] 45</p> <p>1. Follow all interventions and communications as listed above for Moderate Fall Risk</p> <p>2. CONSIDER requesting family or healthcare worker stay at bedside."</p> <p>3 Review of the Fall Prevention policy in section IV. Procedure - Inpatient Fall Occurrence (page 5), indicated: A. Complete head to toe assessment, obtain vital signs and document in the patient's medical record. In addition to a full head to toe assessment, the post-fall assessment should include: 1. Skin assessment 2. Range of motion assessment 3. Pain assessment 4. Neuro assessment..."</p> <p>4 Review of the medical records of 6 patients who had fallen indicated:</p> <p>A. Patient #1 arrived in the ED (emergency department) at 2:46 PM on 4/29/16 and scored 75 (high risk) on the fall risk scale. The patient fell in the ED on 4/29/16 at 4:00 PM and lacked a post fall skin, pain or range of motion assessment.</p> <p>B. Patient #2 was admitted to the MICU (medical intensive care unit) with a fall score of 75 (high risk) done at 1:00 AM. The patient had a fall on 4/29/16 at</p>			

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	<p>3:35 PM with documentation that indicated the patient was left on the bed pan alone while nursing staff left the room to get "supplies"; the bed alarm was inactivated by nursing staff when they placed the patient on the bed pan; and the post fall flow sheet area of the EMR (electronic medical record) was not completed.</p> <p>C. Patient #3 was admitted on 4/27/16 to the oncology unit and had a fall risk score of 85 (high risk). On 4/28/16 at 10:20 PM, a near miss for fall was documented as the patient was ambulating to the bathroom and fell back into the arms of a family member and then set down on the toilet. The patient had been assessed at 30 for fall risk (moderate risk) on admission, but no bed alarm was populated on the fall intervention area of the EMR until the patient scored high risk, 85, after the fall; no "alarm on" area of the fall intervention flowsheet of the EMR populated with the moderate fall scoring assessment; and no post fall flow sheet documentation was completed by the nursing staff.</p> <p>D. Patient #4 was admitted to the pre op area on 4/21/16 for a colon resection after a diagnosis of colon cancer. The patient fell on 4/22/16 at 10:12 PM while a patient on the 5th floor med/surg unit. The fall review committee documented that the patient should have been on</p>			

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	<p>hourly rounding but "it had been about 2 hours since the nurse was in the room", per review of the EMR notes.</p> <p>E. Patient #5 was admitted on 4/25/16 and had a fall score on admission of 35 (moderate risk). A fall occurred on 4/29/16 at 2:18 PM. Documentation by the fall risk review committee indicated "most fall precautions were in place except for the bed alarm, uncertain if patient had turned it off. Pt. went to restroom unassisted, the nurse call light had not been used by the patient...". The "alarm on" section of the fall intervention area of the EMR did not populate.</p> <p>F. Patient #6 was admitted on 4/19/16 and scored 90 (high risk) on admission with an increase to 105 on 4/20/16 at 4:00 AM. The patient fell at 1:05 AM on 4/22/16. There was no post fall flow sheet documentation completed in the EMR, and no "alarm on" section of the EMR was populated.</p> <p>5. At 3:10 PM on 6/7/16, interview with the "policy owner" of the Fall Prevention policy, staff member #53 confirmed that:</p> <p>A. A moderate risk for falls score should populate the bed alarm area of the EMR flowsheet as a bed alarm is required per the addendum for patients who score moderate and high fall risk. This had not populated for patients as listed in 4. above.</p>			

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	<p>B. The four assessments post fall (pain, range of motion, neuro and skin) should be done in the ED as well as on other patient med/surg units.</p> <p>C. The post fall assessment flow sheet does not include the four post fall assessments that are to be done. Currently nurses must use the daily flowsheet for documentation of these assessments, or use nursing notes.</p> <p>6. At 3:35 PM on 6/7/16 and 9:30 AM on 6/8/16, interview with quality and accreditation staff members #50 and #59 confirmed that:</p> <p>A. Documentation, as listed in 4. above, was lacking for the 6 patients related to failing to implement the Fall Prevention policy in various ways.</p> <p>B. It was just found that there was an error with the EPIC (EMR system) program in regard to the "alarm on" section of the fall intervention flow sheet not populating, and that IT (information technology) staff were working to fix the problem.</p>			