

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOSPITAL OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804		
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S 0000 Bldg. 00	<p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00425064 - Deficiency related to the allegation is cited.</p> <p>Date of Survey: 4/23/24</p> <p>Facility Number: 005016</p> <p>QA: 4/26/2024</p>	S 0000	/p>	
S 0930 Bldg. 00	<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 on document review and interview, the Registered Nurse failed to ensure skin assessments/reassessments were completed; failed to ensure any change in patient condition was noted and/or charted in full; and failed to ensure wound measurement was completed on admission, weekly, if there was a decline in the wound condition, and at discharge per facility policy for 1 of 5 medical records reviewed (Patient #1).</p> <p>Findings include:</p> <p>1. Facility policy titled "(PCS.01.01.01) Admission to Clinical Unit, Assessment and Reassessment"</p>	S 0930	<p>="" p=""></p> <p>="" p=""></p> <p>="" p=""></p> <p>="" p=""></p> <p>="" div=""></p> <p>p="" dir="ltr" role="presentation"</p> <p>how="" <="" p=""></p> <p> </p> <p>p="" dir="ltr" role="presentation"</p> <p>on="" 5="" 2="" 2024,="" a=""></p> <p>group="" of="" leaders="" met=""></p> <p>to="" discuss="" the="" factors=""></p> <p>related="" deficiency=""></p> <p>involving="" skin=""></p>	05/28/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Rhonda Culbertson

Quality Coordinator Regulatory

05/14/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>published 11/2023 indicated the following: "III. ASSESSMENT AND REASSESSMENT DOCUMENTATION GUIDELINES: A. A full assessment per shift (defined as "any time there is a hand-off in care") will be completed by RN (Registered Nurse)/LPN (Licensed Practical Nurse): There must be evidence of a full assessment by an RN once every 24 hour period and with any change in level of care or patient condition. B. 2.) Charting by exception is defined as documenting "No change to previous assessment" if actual reassessment is identical to most recent assessment. If any change in patient condition is noted (improvement, decline, or change in any variable within an indicated system), the physical system in which the change occurred must be charted in full. "No change to previous assessment" would not apply to that physical system and cannot be indicated."</p> <p>2. Facility policy titled "(1.21.10) Wound Assessment, Photography, Treatment and Documentation" revised 7/2021 indicated the following: "I. PURPOSE: To assess and document wounds, including wound photography, on admission or discovery of wounds to facilitate: 1) accurate identification of wound type and staging; 3) evaluation of wound healing progress. II. SPECIAL CONSIDERATIONS: C. Wound assessment, measurement and photography will be done as follows by the nurse caring for the patient: 1) on admission to the hospital - any wound other than surgical wounds, especially pressure injuries and venous/arterial/diabetic ulcers with a pressure component; 3) weekly; 4) if there is a decline in the wound condition; and 5) at discharge. III. C. Assess wound using the following parameters: 1) Location. 2) Measurement - using a disposable paper ruler, obtain the following dimensions in centimeters: a.</p>		<p>assessment="" reassessments="" and="" wound="" documentation.="" this="" included="" chief="" nursing="" officer="" quality="" director="" infection="" prevention="" quality="" risk="" regulatory="" over="" care="" team="" critical="" care="" supervisor="" coordinator="" for="" regulatory="" policies="" referenced="" in="" survey="" (lutheran="" hospital="" 1.21.10="" wound="" assessment="" photography="" treatment="" documentation="" lutheran="" health="" network="" pcs.01.01.01="" admission="" clinical="" unit="" reassessment="" were="" reviewed="" it="" was="" discussed="" that="" the="" policy="" is="" currently="" process="" being="" revised.="" revisions="" will="" include="" clarifying="" emphasizing="" responsibility="" primary="" nurse="" assessment="" reassessment="" documentation="" of="" wounds="" new="" education="" be="" provided="" all="" inpatient="" rns="" after="" are="" complete="" approved.="" network="" needs="" no="" revision="" determined="" ambiguity="" caused="" documentation. <="" p="">="" =="" p="">="" =="" p="">="" =="" p=""></p>	

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	<p>Length. b. Width. c. Depth. d. Dead Space. e. Surrounding Skin Erythema - measure the radius of any surrounding redness, and note if there is any associated induration, edema, crepitus, maceration, or bogginess to the skin. 3. Ischemia and Necrosis - note location in wound, or % (percent) of wound involved. Describe color. 4. Drainage/Exudate. 5. Pain. 6. New Tissue Growth/Healing - indicate new pink, or red tissue growth, or use following descriptors: a. Epithelialization - regeneration of epidermis across wound surface. b. Granulation - pink/red, moist new tissue which fills and open wound when it starts to heal; typically appears deep pink or red with irregular "berry-like" appearance. H. Wound Care Plan: 1) Document wound in Incision/Wound section of Cerner (electronic medical record)."</p> <p>3. Review of patient #1's medical record indicated the following:</p> <p>(a.) The patient was admitted on 11/19/23 at 4:27 p.m. and discharged on 12/28/23 at 9:32 a.m. The patient had diagnoses that included but were not limited to cardiac arrest with successful resuscitation, anemia, bilateral pneumonia, acute on chronic renal insufficiency and diabetes mellitus due to underlying condition with hyperglycemia.</p> <p>(b.) A skin assessment dated 11/19/23 at 8:00 p.m. indicated the following: "Incision/Wound: Coccyx. Skin Abnormality Type: Erythema. The medical record lacked documentation and/or patient refusal of wound measurements. Integumentary Assessment dated 11/19/23 at 8:00 p.m. indicated the patient's general skin integrity was intact.</p> <p>(c.) A wound care nurse note dated 11/20/23 at</p>		<p>="" p="">>Complaint Number: IN00425064</p> <p>="" p="">>Found to be substantiated; State deficiency related to the allegation is cited.</p> <p>="" p="">>Date of Survey: 4/23/2024</p> <p>="" p="">>ID PREFIX TAG: S930</p> <p>="" p="">></p> <p>="" p="">>In response to complaint number IN00425064 for Lutheran Hospital, Fort Wayne, Indiana. The below information has been addressed to correct the deficiency 410 IAC 15-1.5-6 NURSING SERVICE. Thank you for the opportunity to address the concerns outlined in your letter dated April 29, 2024. Lutheran Hospital is dedicated to providing compassionate, quality care with the best possible experience to every patient, every time, and to making a positive impact on our community.</p> <p>="" p="">>1. How are you going to correct the deficiency?</p> <p>="" p="">>A. On 5/2/2024, a group of leaders met to discuss the factors related to the deficiency involving skin assessment/reassessments and wound assessment and documentation. This group included the Chief Nursing Officer, the Chief Quality Officer, the Director of Infection Prevention and Quality, the Director of Risk and Regulatory, the Director over the</p>	

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	<p>11:20 a.m. indicated the following: "Incision/Wound Care Grid. Type: Other: Pt (Patient) unable to be turned at present. From photo on chart, patient has hypopigmented line in coccyx area, possibly from prior skin breakdown. No breakdown noted at present."</p> <p>(d.) The medical record lacked documentation and/or patient refusal of wound reassessments for the patient's coccyx on 11/24/23 and 11/25/23 for night shift (5:00 p.m. to 5:00 a.m.).</p> <p>(e.) A skin assessment dated 11/29/23 at 6:39 p.m. indicated the following: "Incision/Wound: Coccyx. Skin Abnormality Type: Erythema. The medical record lacked documentation and/or patient refusal of wound reassessment for the patient's coccyx on 11/30/23.</p> <p>(f.) A wound care note dated 12/1/23 at 4:05 p.m. indicated the following: "Incision/Wound Care Grid. Type: Other: coccyx assessed, pigment changes remain, skin is peeling but intact. May have been an area of prior skin breakdown at one time. Description: Closed/Resurfaced. Color: Pink. Drainage: None. Dressing: Foam."</p> <p>(g.) A wound care nurse note dated 12/14/23 at 9:45 a.m. indicated the following: "Incision/Wound Care Grid. Type: Other: moisture associated dermatitis. Location: coccyx. Description: Edges separated, tender. Color: Pink, Red. Drainage: None. Incision/Wound Surrounding Tissue Area: Other: chronic pigment changes also noted, along with MASD (moisture associated skin damage). Cleansing/Irrigation: Other: peri care wipes. Dressing: Other: calazime ointment applied."</p> <p>(h.) A wound care nurse note dated 12/19/23 at</p>	<p>Wound Care Team, the Director of Critical Care, the Supervisor of Wound Care Team and the Quality Coordinator for Regulatory. The policies referenced in the survey (Lutheran Hospital 1.21.10 "Wound Assessment, Photography, Treatment and Documentation" and Lutheran Health Network PCS.01.01.01 "Admission to the Clinical Unit, Assessment and Reassessment") were reviewed and it was discussed that the Lutheran Hospital policy 1.21.10 is currently in the process of being revised. The revisions will include clarifying and emphasizing the responsibility of the primary nurse for assessment, reassessment and documentation of wounds. New education will be provided to all inpatient nurses after the revisions are complete and approved. The Lutheran Health Network policy PCS.01.01.01 needs no revision. It was determined that ambiguity in the Lutheran Hospital policy caused deficiency in the skin/wound documentation. ="" p="">B. On 5/10/2024, all current CIC (Coronary Intensive Care Unit) and CVIC (Cardiovascular Intensive Care Unit) nurses were assigned the online learning module "Assessment and Reassessment - Guidelines as stated per Lutheran Health Policy" with a due date of 5/28/2024. These are the</p>		

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	<p>3:15 p.m. indicated the following: "Incision/Wound Care Grid. Type: moisture associated dermatitis. Location: inner buttocks and coccyx. Description: (Blank). Color: White. Drainage: None. Incision/Wound Surrounding Tissue Area: Maceration. Dressing: Other: clear aid ointment applied, calazime recommended if available."</p> <p>(i.) The medical record lacked documentation and/or patient refusal of wound reassessments for the patient's coccyx on 12/23/23 for day shift (5:00 a.m. to 5:00 p.m.).</p> <p>(j.) A skin assessment dated 12/25/23 at 6:00 a.m. indicated the following: "Incision/Wound: Coccyx. Skin Abnormality Type: Pressure ulcer. Incision, Wound Dressing: Foam. Incision, Wound Dressing Assessment: Clean, Dry, Intact. The medical record lacked documentation of assessment/reassessment of the patient's coccyx wound on 12/25/23 for night shift. (5:00 p.m. to 5:00 a.m.)</p> <p>(k.) The medical record lacked documentation and/or patient refusal of wound reassessment on the patient's coccyx on 12/26/23 and 12/27/23. The medical record lacked documentation of wound reassessment and wound measurements of the patient's coccyx at discharge from the facility on 12/28/23. It is undetermined by review of the patient's medical record if the patient's coccyx wound improved, worsened and/or healed upon discharge from facility on 12/28/23. The medical record also lacked documentation of weekly measurements of the patient's coccyx wound.</p> <p>4. During an interview with A5 (Manager of Cardiovascular Intensive Care - East Unit) on 4/23/24 at approximately 3:00 p.m., he/she verified</p>		<p>two units where the deficiency occurred. This lesson covers all aspects of skin and wound assessment and reassessment as outlined in the policies detailed in section 1.A. above. This content is covered in the New Hire Orientation for nurses, to be completed within 90 days of hire.</p> <p>="" p="">C. All current CIC and CVIC nurses will complete an attestation to demonstrate their understanding of and compliance with skin and wound assessment and documentation as outlined above in 1.B.</p> <p>="" p="">2. How are you going to prevent the deficiency from occurring in the future?</p> <p>="" p="">A. Regular audits will be completed on a monthly basis as follows: A total of 15 charts of patients from the CIC and CVIC units that had non-surgical wounds will be audited each month until at least 90% compliance of skin and wound assessment and documentation has been achieved for 3 consecutive months. The results of these audits will be reported to the Chief Nursing Officer and to the Quality Council on a monthly basis.</p> <p>="" p="">B. Lutheran Hospital will reinforce that these specific policies are followed by ensuring corrective action is taken for remediation for non-adherence of the policy among staff as follows:</p>	

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	<p>that wounds should be assessed at admission, with any change to a higher/lower level of care, and/or every shift.</p> <p>5. During an interview with A4 (Director of Quality), A7 (Supervisor of Wound/Ostomy Department) and A6 (Network Health Information Director) on 4/23/24 at approximately 4:00 p.m., they verified the medical record information for Patient #1. A4 and A7 verified that the nursing staff chart by exception, if a wound was not charted on and/or if the integumentary assessment indicated the patient's skin integrity was intact then the wound was resolved.</p> <p>6. During an interview with A5 on 4/23/24 at approximately 4:15 p.m. he/she verified that the nursing staff chart by exception and if a wound was healed/resolved when staff assessed it then they would not chart anything.</p>		<p>="" p="">>I. All online learning modules and attestations must be completed for current CIC and CVIC nurses by the date listed below in section 4.</p> <p>="" p="">>II. Corrective action will occur for non adherence to these specified policies as stated in the Employee Handbook: The disciplinary action that is appropriate for any particular act or misconduct depends upon many factors including the employee's length of service, prior disciplinary record, the seriousness of the misconduct, and the impact of the misconduct on others. the disciplinary action that is administered for any particular act or misconduct rests in the employer's sole discretion. Examples of disciplinary action include, in no particular order, informal counseling, verbal and/or written warnings, investigative or disciplinary suspension, probation, demotion and separation.</p> <p>="" p="">>3. Who is going to be responsible for numbers 1 and 2 above?</p> <p>="" p="">> The Chief Nursing Officer will be responsible for ensuring that actions listed in numbers 1 and 2 are completed.</p> <p>="" p="">>4. By what date are you going to have the deficiency corrected?</p> <p>="" p="">>All corrective actions will be completed by 5/28/2024.</p> <p>="" span="">></p>	

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