

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

PRINTED: 05/20/2024

FORM APPROVED

OMB NO. 0938-039

| | | | | | | | |
|--|--|---|--|--|---|--|----------------------------|
| 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 04/30/2024 | |
| NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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 |
| S 0000 Bldg. 00 | This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00401237 - State deficiency related to the allegations is cited at S0930. Date of Survey: 4/30/24 Facility Number: 005020 QA: 5/6/2024 | | | S 0000 | | | |
| S 0930 Bldg. 00 | 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 ensure a Registered Nurse followed facility policy related to pain assessments/reassessments for 1 of 5 patients (Patient #1). Findings include: 1. Facility policy titled, "Standards for Pain Management, Assessment, and Monitoring", PolicyStat ID 12381204, with an approved date of 4/2021, indicated the following: "III. Procedure: 4. Assessment of pain or risk of pain should take place at the following times: a. Upon admission. b. With any new report of pain. c. When completing | | | S 0930 | 1 How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. a Formally share citation and share the "why" to all nursing staff via electronic communication on May 17, 2024. b Review Emergency Nursing Standards of Practice for pain assessment by ED Nurse Director by June 15, 2024. c The following policies: Standards for Pain Management, Assessment, and Monitoring, and | | 06/20/2024 |

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

TITLE

(X6) DATE

Sarah Nitza

Accreditation Data Coordinator

05/16/2024

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.

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

PRINTED: 05/20/2024
FORM APPROVED
OMB NO. 0938-039

| | | | | | | | |
|--|---|---|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150021 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 04/30/2024 | |
| NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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 |
| | <p>routine assessments based on unit standards of care. d. Before, during, and after medical procedures and treatments. 5. Document pain assessment, reassessment, pain/comfort management interventions, patient response to interventions, and patient education in the Electronic Medical Record (EMR). 6. Pain assessments include pain score from the appropriate pain assessment tool. The assessment may also include location, duration, and type of pain. 8. Pain reassessment includes the patient's perception or response as measured by the appropriate pain assessment tool. C. Guidelines for Pain Assessment and Patient Monitoring: 1. Monitoring guidelines apply to both PRN (as needed) and scheduled doses of opioids. IV (intravenous) Medications: Reassess pain level in about an hour. IV Opioids: Hydromorphone. Within approximately 15 minutes of the first dose, assess: Pain level. Subsequent doses, reassess...in about an hour following administration. Repeat 15 minute assessment if doses increased or changing from one opioid to another."</p> <p>2. Facility policy titled, "Emergency Nursing Standards of Practice", PolicyStat 12260084, with an approved date of 2/2022, indicated the following: "III. Procedure: 10. Related Standards of Patient Care: e. The patient will be assessed for changes and progress towards meeting outcome goals including pain management and discharge objectives."</p> <p>3. A review of Patient #1's medical record indicated the following:</p> <p>(a.) Review of a triage note for Patient #1 dated 1/31/23 at 5:40 p.m. indicated the patient's chief complaint was back pain, had back surgery this</p> | | | | <p>Emergency Nursing Standards of Practice, will be reviewed and expectations reinforced with nursing staff via electronic communication. May 17, 2024.</p> <p>i Nurse manager and Nurse Supervisor rounding with staff weekly to discuss pain management, documentation, and nursing standards of care, started April 30, 2024, and will be ongoing for 2024.</p> <p>ii Daily in person huddles to review the pain management policy and nursing standards of practice start May 27, 2024, on day and evening shift.</p> <p>d Audit pain assessments and reassessments ongoing</p> <p>i Audit 30 charts a month until 90% compliant for 3 consecutive months. Start June 1, 2024.</p> <p>ii Audit results will be shared monthly with nursing staff via electronic huddle board.</p> <p>2 How are you going to prevent the deficiency from recurring in the future?</p> <p>a Reviewed education and updated information that is shared at Jump Start (new nurse orientation program), start June 1, 2024.</p> <p>i Pain management policy; assessment, reassessment, and documentation standards</p> | | |

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

PRINTED: 05/20/2024
FORM APPROVED
OMB NO. 0938-039

| | | | | | | | |
|--|---|--|--|---|---|--|----------------------------|
| 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 04/30/2024 | |
| NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED 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 |
| | <p>morning and having severe pain. Patient #1 indicated that (his/her) pain level was 10 out of 10.</p> <p>(b.) A review of the medication administration record for Patient #1 indicated the patient was administered hydromorphone (an opioid medication) 1 milligram via IV push on 1/31/23 at 6:19 p.m. The medical record for Patient #1 lacked documentation of a pain level assessment prior to and after the administration of the pain medication.</p> <p>(c.) A review of the medication administration record for Patient #1 indicated the patient was administered Norflex (a muscle relaxant medication) 60 milligrams via IV push on 1/31/23 at 7:17 p.m. The medical record for Patient #1 lacked documentation of a pain level assessment prior to and after the administration of the medication.</p> <p>(d.) A review of the medication administration record for Patient #1 indicated the patient was administered hydromorphone 1 milligram via IV push on 1/31/23 at 8:56 p.m. The medical record for Patient #1 lacked documentation of a pain level reassessment after the administration of the pain medication. The patient had a pain level of 10 out of 10 on 1/31/23 at 8:56 p.m.</p> <p>(e.) A review of the medication administration record for Patient #1 indicated a lidocaine 4% (percent) patch (local anesthetic) was applied transdermal to the patient's left hip on 1/31/23 at 9:34 p.m. The medical record for Patient #1 lacked documentation of a pain level assessment prior to and after the administration of the pain medication.</p> <p>(f.) Review of the Patient Care Timeline for Patient #1 indicated that the patient was discharged on</p> | | | | <p>b Nursing staff follow up.</p> <p>Targeted follow up with nursing staff that are not following the policy.</p> <p>Positive reinforcement for exceptional assessment and documentation for pain management</p> <p>c Nursing staff member to be named "Pain Champion" to assist at the elbow with education and driving best practices for pain management. Start June 1, 2024.</p> <p>d Ongoing random quarterly audits once 90% compliant.</p> <p>30 chart audits quarterly</p> <p>e Nurse manager and nurse supervisor have yearly nursing staff check-in that include review of the pain policy and standards of practice. Started May 1, 2024.</p> <p>3 Who is going to be responsible for numbers 1 and 2 above?</p> <p>a ED Director will review Emergency Nursing Standards of Practice</p> <p>b ED Manager</p> <p>c ED Nurse Supervisor</p> | | |

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

PRINTED: 05/20/2024
FORM APPROVED
OMB NO. 0938-039

| | | | | | | | |
|--|---|---|--|--|--|--|----------------------------|
| 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 04/30/2024 | |
| NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP COD 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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 |
| | 1/31/23 at 9:58 p.m. The medical record for Patient #1 lacked documentation of a pain level reassessment prior to the patient discharging from the facility. 4. During an interview with A4 (Emergency Department Nurse Manager) on 4/30/24 at 3:14 p.m., A4 verified the medical record information for Patient #1. | | | | 4 By what date are you going to have the deficiency corrected? June 20, 2024 | | |