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	150100	A. BUILDING 00 B. WING	03/10/2020

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S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint # IN00319414 Substantiated: Deficiency related to the allegations is cited. Unrelated deficiency is cited. Survey Dates: 3/9/20 and 3/10/20 Facility Number: 005089 QA: 3/18/20	S 0000		
S 0838 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (b)(1) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsiblities. These bylaws and rules shall: (1) be approved by the governing board; Based on document review and interview, the medical staff (MS) failed to enforce their rules and hospital policies to carry out responsibilities for completion of a discharge summary that included all required components by 1 physician (MD1) for 1 of 5 patients (P4). Findings include: 1. Review of the MS rules, titled Medical Staff Policy & Procedure, amended 12/01/2017, indicated the following: A discharge summary	S 0838	**410 IAC 15-1.5-5 Medical Staff** **The discharge summary is required by St. Vincent Evansville Medical Staff Bylaws to be completed within 48 hours of the discharge or transfer of the patient. This education will be provided to the Medical Staff via the Medical Executive Committee meeting.** **April 7, 2020 – first presentation**	05/07/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	shall be completed on all patients... the discharge summary is to be dictated or electronically completed within 48 hours of discharge. Discharge summaries will address, at a minimum, the following (not all inclusive): summarization of the hospital clinical course of the patient; dietary instructions; disposition and follow-up recommendations; condition of the patient at the time of discharge and discharge diagnoses. Review of PolicyStat ID: 6714021, last revised 7/25/19, indicated the following: Required components of the medical record: Discharge summary including discharge diagnosis; reason for hospitalization; treatment and services provided, condition and disposition at discharge. 2. In medical record review of patient P4, the discharge summary, authored by physician MD1, dated 10/25/19 at 0936 hours, lacked documentation of a summarization of the hospital clinical course of the patient; dietary instructions; disposition and follow-up recommendations; condition of the patient at the time of discharge and/or discharge diagnoses. 3. On 3/10/20, between approximately 4:30 PM and 5:00 PM, A1, Manager of Risk Management, indicated that MD1 had had no reported issues, counselings or reprimands documented for 2019.		**to Medical Staff** **May 7,2020 – Second presentation to Medical Staff** **Completion date 5/7/2020** **Compliance – 95%** **Health Information Management audits 100% of inpatient records for the presence of a discharge summary within 48 hours. When a discharge summary is not present, a deficiency is issued to that provider. A monthly report of compliance and outstanding deficiencies is shared with the Chief Medical Officer and Medical Affairs monthly. The goal and expectation of compliance is 100%. This audit, with reporting to the CMO, continues indefinitely, Oversight provided by Chief Medical Officer and Med Exec Committee**	
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a			

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	registered nurse. The service shall have the following: (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.			
	Based on document review and interview, the nurse executive failed to ensure that nursing personnel followed established policies and procedures for 5 processes; skin care, bowel training, nursing (assessment) documentation, individualized plan of care, and event reporting on 1 unit of the hospital (rehabilitation). Findings include: 1. Review of facility policies indicated the following: PolicyStat ID: 5322366, last revised 8/27/18:	S 0912	410 AIC 15-1.5-6 Nursing Services Rehab associates were educated November 11, 2020 through April 30, 2020 on Skin bundle and assessment, including hygiene and plan of care Rehab associates were educated November 11, 2020 through April 30, 2020 on the requirements of documentation on the following:	04/30/2020

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	The Braden Scale is a pressure ulcer risk assessment scale... A person with a score of 18 or less is at risk. Initiate Skin Precautions (Nursing Standard) for patients with a Braden Scale Score of 18 or less. Clean and dry the skin as soon as possible after each incontinent episode... Establish a schedule of turning and position changes... Turn and reposition the patient at least every two hours... Control or minimize skin exposure to moisture due to incontinence. PolicyStat ID: 4809351, last revised 4/10/18: Establish a bowel evacuation time following a regularly scheduled meal. At the same time every day, place the patient in a normal defecation position on a bedside commode or in the bathroom. Maintain record of the patient's bowel habits. The patient's response to the bowel training program is documented in the nursing notes. PolicyStat ID: 4862256, last revised 4/24/18: The direct care nurse will perform a head to toe assessment on each patient per unit policy (minimum or every 12 hours), or with change of assigned direct care nurse... If a system assessment is found to be "Within Defined Limits" as listed below the nurse may document "WDL". If some findings are normal but one or more findings are outside the defined limits the nurse may document "WDL Except" then document the abnormal findings only. PolicyStat ID: 4552339, last revised 2/2/18: The Overall Plan of Care includes: Expected intensity (number of hours per day) Expected frequency (number of days		Head to toe assessment q 12 hours Bowel and Bladder training, when applicable, including documentation, hygiene, and Plan of care All actions completed on this date: 4/30/2020 Monitor or Metric: Compliance of Skin Bundle assessment and intervention including hygiene when indicated and nursing plan of care Head to Toe assessment q 12 hours by nursing Bowel training assessment and intervention per policy, including hygiene when indicated Bladder training assessment and intervention per policy including hygiene when indicated When documentation/ situations indicate the need for an event report, an event report has been entered. Frequency of Monitoring 10 chart audits per month with a goal of 95% compliance for 3 months. After the initial 3 months, the audit may be discontinued with a sustained compliance for 3 months of 95%	

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	per week) PolicyStat ID: 6881793, last revised 11/5/19: Definitions: Adverse Event/Event: A happening or occurrence that is not part of the routine care of a particular patient or the routine operation of the healthcare entity. Harm: An impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom. Procedure: When it is discovered that an adverse event, error, sentinel event or near miss event occurred in the healthcare inpatient or ambulatory setting, the associate should: Enter the event into the Event Reporting System (ERS)... 2. Review of medical records (MR) indicated the following: skin care, bowel training, nursing (assessment) documentation, individualized plan of care, and event reporting on 1 unit of the hospital (rehabilitation). The MR of patient P4 indicated the following: The patient was admitted to the rehabilitation unit on 10/2/19 and discharged to home on 10/25/19. Preadmission Screening indicated the patient had no pressure ulcers present upon admission and that the patient's level of function for "Bed Mobility" was Total: Mod (moderate) to Max (maximum) A (assist) x 2 with VC (Verbal Cues). The initial skin assessment, completed on 10/2/19 at 15:26 hours indicated the patient's integument was WDL (within defined limits) Except; incision with a Braden score of 14 (at risk for skin breakdown/pressure ulcer). The assessment lacked documentation of where the incision was located and or characteristics of the incision. Nursing care plan goals included, but were not limited to, initiation of a bowel program. The		Oversight: Director of Rehabilitation and Chief Nursing Officer Data will be reported through e Focus on CARE Accreditation Leadership team, in which data flows to the Council on Clinical Excellence and then the Board of Directors EVENT REPORTING Risk Management provided education to Rehab RNs, PCTs and therapists, and wound ostomy nurse regarding event reporting and the reporting of skin breakdown and pressure ulcers. Completion date 4/30/2020 **Monitor or Metric**: **Frequency of Monitorin**g 10 chart audits per month with a goal of 100% compliance for 3 months. After the initial 3 months, the audit may be discontinued with a sustained compliance for 3 months of 100% Oversight provided by Director of Rehabilitation and Risk Management **Data will be reported through Risk Management report which flows to the Council on Clinical Excellence and then the Board**	

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	care plan lacked documentation of nursing having established a bowel evacuation time following meals and lacked documentation of having set a regular daily time for staff to place the patient on a commode, as per policy. The MR indicated the paraplegic patient was incontinent of bowel. The MR lacked documentation of the patient having had perineal or other hygiene care promptly following bowel movements (BM) as follows (not all inclusive): On 10/2/19 at 1927 until 2103 hours. On 10/3/19 at 0915 hours until 10:01 hours. On 10/5/19 at 2226 hours, together with 10/6/19 at 0815 hours, until 10/6/19 at 1210 hours. On 10/6/19 at 1306 hours, at 1934 hours and at 1938 hours, the MR lacked documentation of incontinence care/hygiene performed until 1934 hours. On 10/7/19 at 0850 hours until 1452 hours. On 10/8/19 at 1944 hours, "toileting offered" was noted. The note lacked documentation of the outcome. On 10/9/19 at 1900 hours until 2126 hours. The MR lacked documentation of head to toe assessments (lacked skin assessment) every 12 hours in accordance with hospital policy, as follows (not all inclusive): Between 10/6/19 at 1938 hours and 10/7/19 at 2044 hours. Between 10/13/19 at at 2113 hours and 10/14/19 at 1908 hours. Between 10/15/19 at 2030 hours and 10/16/19 at 2139 hours. MR documentation, titled Adult Plan of Care, dated 10/25/19 at 1150 hours indicated the following: Talked with patient...Reviewed with patient and family...All skin pressure areas examined. "Small area of maceration from moisture on left buttock in skin integrity noted." The MR lacked documentation of the patient having been repositioned every 2 hours in accordance with hospital protocol as follows (not all inclusive): Between 10/2/19 at 1526 hours and		**of Directors.**	

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	10/2/19 at 2103 hours. Between 10/3/19 at 2137 hours and 10/4/19 at 0845 hours Between 10/4/19 at 2203 hours and 10/5/19 at 0314 hours Between 10/5/19 at 0314 hours and a physical therapy (PT) session on 10/5/19 at 1636 hours - Note: On 10/5/19 at 1149 hours, the patient's position was indicated as "resting in bed"; therefore unable to determine change in position. Between 10/5/19 at 1948 (resting in bed) hours to 2134 hours (resting in bed) and 10/6/19 at 1022 hours with PT. Between 10/6/19 at 1938 hours (resting in bed) to 10/7/19 and 1014 hours with PT. Between 10/8/19 at 2029 hours and 10/9/19 at 1000 hours. Between 10/10/19 at 0253 hours and 10/10/19 at 1044 hours with OT (Occupational Therapy). Between 10/21/19 at 0143 hours and 10/21/19 at 0911 hours with OT. Between 10/22/19 at 0018 hours (supine) to 10/22/19 at 0936 hours (supine) to 1053 hours with OT. Between 10/23/19 at 2226 hours (right side) to 10/24/19 at 0158 hours (resting in bed) to 10/24/19 at 0854 with OT. The MR of patient P6 indicated the following: The patient was admitted to the rehabilitation unit on 10/1/19 and discharged on 10/29/19. Preadmission Screening lacked documentation of whether the patient had pressure ulcers present (neither no nor yes was marked/the area was blank) upon admission to the unit. The patient's level of function for "Bathing" was indicated to be "dependent for perianal care post BM" and "Rolling max A of 2-3 to			

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	dependent". The initial nursing skin assessment, documented on 10/1/19 at 1500 hours, indicated the following: Skin WDL except; ecchymotic, abrasion. The assessment lacked documentation of where the ecchymosis and/or abrasion was located and or characteristics of the conditions. The patient's Braden risk score was 12. Skin assessment on 10/14/19 at 0829 hours indicated the patients' skin was WDL except; wound, scab. The assessment lacked documentation of where the wound and/or scab was located and lacked documentation of characteristics of the conditions. MR documentation indicated that the patient was seen by a WOC (wound, ostomy, continence) specialist for Wound/Skin Evaluation on 10/14/19 at 1637 hours. The assessment/evaluation indicated the patient had developed a right coccygeal skin impairment that was determined to be a stage 2 pressure wound. The MR lacked documentation of head to toe assessments (lacked skin assessment) every 12 hours in accordance with hospital policy, as follows (not all inclusive): Between 10/2/19 at 0718 hours and 10/4/19 at 2105 hours. Between 10/7/19 at at 0745 hours and 10/8/19 at 0804 hours. Between 10/8/19 at 0804 hours and 10/9/19 at 0852 hours. Between 10/9/19 at 0852 hours and 10/10/19 at 0006 hours. The MR lacked documentation of the patient having been repositioned every 2 hours in accordance with hospital protocol as follows (not all inclusive): Between 10/1/19 at 2200 hours and 10/2/19 at 1054 hours, at which time the patient was in OT. Between 10/2/19 time with PT (unable to determine specific time); note authored at 1550 hours with a total therapy time of 35 minutes and			

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	10/3/19 OT note authored at 0959 hours with a total therapy time of 55 minutes. Note: The Patient Care Flowsheet lacked documentation of repositioning at any time between 10/1/19 at 2200 hours and 10/3/19 at 1033 hours. Between 10/4/19 at 2120 hours and 10/5/19 at 0738 hours. Between 10/8/19 at 2204 hours and 10/9/19 at 0852 hours. Between 10/11/19 at 1934 hours and 10/12/19 at 0838 hours. 3. Review of facility incident reports lacked documentation of the rehabilitation unit having had any incidents of hospital acquired pressure ulcers between 7/1/19 and 12/31/19. 4. The following was indicated in interview: On 3/10/20, between approximately 4:15 PM and 4:30 PM, A4, Director of Rehabilitation, verified that patients in rehab are to be repositioned every 2 hours even throughout the night. On 3/10/20, between approximately 4:30 PM and 5:00 PM, A3, Risk Management, verified lack of MR documentation, for patient's P4 and P6, as noted above. On 3/10/20, between approximately 4:30 PM and 5:00 PM, A1, Manager of Risk Management, verified that no incident reports related to HAPU (hospital acquired pressure ulcers) had been documented/reported for the rehab unit between 7/1/19 and 12/31/19. A1 acknowledged that the MR of P6 indicated he/she did acquire a pressure ulcer during his/her stay in the rehab unit.			