STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150017	A. BUILDING 00 B. WING	06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	The visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00248432 Substantiated: No deficiency related to the allegations is cited. Unrelated deficiency cited. Survey Date: 6/11/19 Facility Number: 005016 QA: 6/20/19	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 upon document review and interview, the nurse executive failed to ensure that the policy/procedures for medical record documentation and patient belongings were followed for 3 of 5 medical records (MR) reviewed (Patient's #1, 2 & 3). Findings include: 1. Review of the policy/procedure Content of the Medical Record (approved 10-18) indicated the following: "The collection of information concerning a patient and his or her health care that is created and maintained in the regular	S 0930	**Plan of correction:** **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** ·For the three records that were missing the documentation for the belonging sheet upon admission to the facility, we are unable to correct those records to include the inventory sheet as this is something that should have been done at admission and can't	07/25/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150017	A. BUILDING 00 B. WING	06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	course of business made by a person who has knowledge of the acts, events, or diagnoses relating to the patient." 2. Review of the policy/procedure Handling of Patient Belongings (approved 6-2018) indicated the following: "May be performed by all nursing associates ...To ensure patient belongings are secured upon entry into ER ...or admission to the facility ...Complete Patient Belonging Sheet on admission, with any transfer, and at dismissal. If there are any lost items, an ERS [event reporting system incident report] must be completed." 3. Review of the MR for Patient's #1, 2 & 3 lacked documentation indicating a patient belonging sheet was initiated on admission to the facility. 4. On 6-11-19 at 1440 hours, the Director of Quality, A2 confirmed the MR for Patient's #1, 2 & 3 lacked the indicated documentation.		be reproduced. ·Prior to the survey process it was noted that The Lutheran Hospital nursing policy 3.11.16 *Handling of Patient Belongings/Valuables* was not accurately describing the process for documenting the inventory of patient belongs and a workgroup was reviewing and purposing changes. ·The Lutheran Hospital nursing policy 3.11.16 *Handling of Patient Belongings/Valuables* was revised by Director of Nursing with the collaboration of other nurse leaders to reflect the electronic format and process for documenting the inventory of patient belongs. This policy will be approved by 7/19/2019. ·The Director of Nursing and department nurse leaders will reeducate all nursing staff regarding the nursing policy 3.11.16 and required chart documentation. This will be completed via e-mail communication with all nursing on July 25, 2019. **2.How are you going to prevent the deficiency from recurring in the future?** ·The Quality Department will complete an audit of a minimum of 5 charts per nursing unit to verify patients have the appropriate documentation for patient belongs. The auditor will review with the Quality Director and the Director of Nursing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150017	A. BUILDING 00 B. WING	06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			audit results. Any non-compliance and follow up actions will be submitted through the Patient Safety Committee. ·This education will also be added to the nursing orientation program on July 25, 2019. **3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?** ·The Director of Nursing will be responsible for the plan of correction. **4.By what date are you going to have the deficiency corrected?** ·July 25, 2019	