STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150021	A. BUILDING 00 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW REGIONAL MEDICAL CENTER	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 the investigation of one state licensure complaint. Complaint Number: IN00320986 Substantiated: Deficiency related to the allegations is cited. Date of survey: 9/26/22 Facility number: 005020 QA: 9/30/2022 IDR Committee met on 11/14/2022. Tag S0930 modified.	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 Registered Nurse failed to ensure a patient was assisted with repositioning/turning every two hours per physician order for 1 of 5 medical records (MR) reviewed (Patient #1) and failed to ensure skin reassessments were completed every eight hours per facility policy for 1 of 5 medical records reviewed (Patient #1). Findings include:	S 0930	**Citation #1** - Based on document review and interview, the Registered Nurse failed to ensure a patient was assisted with repositioning/turning every two hours per physician order for 1 of 5 medical records (MR) reviewed (Patient #1) 1- How are you going to correct the deficiency? If already	11/01/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Nitza	Accreditation Data Coordinator	12/02/2022

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	1. Facility policy titled "Nursing Assessment and reassessment - Admitted Patients" last reviewed/revised on 6/2017 indicated the following: "...B. Reassessment...2. Reassessments will be completed every 8 hours at a minimum..." 2. Facility policy titled "Skin Assessment and Prevention of Pressure Injuries" last approved on 1/2017 indicated the following: "...I. POLICY STATEMENT...The incidents of pressure injuries will be reduced, and when possible, eliminated (as a potential patient outcome) by implementing routine skin assessments...and nursing actions to protect skin...II. DEFINITIONS OF TERMS...A. Pressure Injury: "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear"...III. PROCEDURE...1. Skin assessment will include inspection of bony prominences...Skin will be assessed for pressure injuries, scars, redness, irritation, swelling, bruises, irruptions, excoriations, maceration, or other unusual skin conditions...2...a. Wound Care Consult...may be initiated by nurses for skin integrity issues at any time. 3. Skin assessment and any alteration in skin integrity will be documented in the Electronic Medical Record. 3. Review of patient #1's medical record indicated the following: (A) The patient was admitted on 12/23/19 for surgery and discharged on 12/30/19 at 5:18 p.m. The patient had diagnoses that included but were not limited to gangrene of toes on right foot, right below knee amputation, end stage renal disease on hemodialysis, peripheral vascular disease, and coronary artery disease. (B) A physician order dated 12/24/19 at 8:14 p.m.		corrected, include the steps taken and the date of correction. Education was provided to nursing staff that skin assessment needs to be completed and documented in the electronic medical record every 8 hours per policy. 2- How are you going to prevent the deficiency from recurring in the future? Unit to complete 30 audits per month on every 8 hour skin assessment documentation. Goal of 90% or greater for 3 consecutive months. Once goal is reached, ongoing monitoring to include 10 audits per month with a goal of 3 consecutive months with 90% or greater compliance. 3- Who is going to be responsible for numbers 1 and 2 above, (i.e. director, supervisor, etc.)? Nursing Manager and Nursing Director 4- By what date are you going to have the deficiency corrected? 11/1/2022 **Citation #2 -** Based on document review and interview, the Registered Nurse failed to ensure skin reassessments were completed every eight hours per facility policy for 1 of 5 medical records reviewed (Patient #1). 1- How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Staff provided education on	

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	indicated to turn the patient every two hours to start on 12/24/19 at 10:00 p.m. and discontinued on 12/30/19 at 7:24 p.m. (C) The medical record lacked documentation of patient repositioning/turning every two hours and/or patient refusing repositioning/turning every two hours for the following dates and times: (a.) On 12/25/19 at 8:00 a.m., 10:00 a.m. and 10:50 p.m. (b.) The patient was documented as being in the supine position on 12/25/19 at 11:40 a.m., 1:25 p.m., 2:45 p.m., 4:29 p.m. and 6:55 p.m. (c.) On 12/26/19 at 10:00 a.m. and 4:30 p.m. (d.) On 12/27/19 at 12:25 p.m. (e.) On 12/28/19 at 5:00 a.m. (f.) On 12/30/19 at 2:00 a.m. and 12:30 p.m. (D) Skin assessment dated 12/24/19 at 6:47 a.m. indicated the following: "Skin 1...Location: R (right) arm, R leg...Skin Integrity: Bruising...Skin Turgor: Epidermis thin with loss of subcutaneous tissue (Loose)...Skin 2: Right Arm-generalized bruising...Skin 3: Right Leg-Surgical incision...Skin 4: Coccyx-Abrasion/skin tear..." (E) The medical record lacked documentation of skin reassessments of the patient's coccyx and/or patient refusing of skin reassessments of coccyx every eight hours. The medical record indicated the skin assessment of the coccyx was completed on the following dates and times: (a.) On 12/24/19 at 6:47 a.m. (b.) On 12/27/19 at 10.22 a.m. and 7:34 p.m. (c.) On 12/28/19 at 7:39 p.m. (d.) On 12/29/19 at 6:47 a.m. (e.) On 12/28/19 at 9:05 p.m.		10/7/22 to pull back Mepilex dressing assess skin and document assessment in medical record. 2- How are you going to prevent the deficiency from recurring in the future? Unit to complete 10 audits per month on assessing skin under mepilex and every 2 hour turns. Goal of 90% or greater for 3 consecutive months. Once goal is reached, ongoing monitoring to include 10 audits per month with a goal of 3 consecutive months with 90% or greater compliance. 3- Who is going to be responsible for numbers 1 and 2 above, (i.e. director, supervisor, etc.)? Nursing Manager and Nursing Director 4- By what date are you going to have the deficiency corrected? 11/1/2022	

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	(F) Skin assessment by Wound Care Nurse dated 12/27/19 at 3:30 p.m. indicated the following: (a.) "...Wound 12/27/19 Pressure Injury Sacrum deep tissue injury...Date First Assessed/Time First Assessed: 12/27/19...[at]...[3:30 p.m.] Present on Hospital Admission: No. Primary Wound Type: Pressure Injury. Location: Sacrum. Wound Description...deep tissue injury...Site Assessment: Purple. Peri-wound Assessment: Clean/Dry; Intact. Wound Length (cm) [centimeters]: 5 cm. Wound Width...9.5 cm. Wound Depth...0 cm...Wound Surface Area (cm^2) [square centimeters]...47.5 cm^2...Pressure Injury Stage: DTPI [Deep Tissue Pressure Injury]... (b.) "...Wound 12/27/19 Pressure Injury Coccyx unstageable...Date First Assessed/Time First Assessed 12/27/19...[at]...[3:40 p.m.]...Present on Hospital Admission: No. Primary Wound Type: Pressure Injury. Location: Coccyx. Wound Description...unstageable...Site Assessment: Slough present. Peri-wound Assessment: Purple. Wound Length (cm): 0.8 cm. Wound Width (cm): 0.5 cm...Wound Surface Area (cm^2) 0.4 cm^2...Wound Surface Color: Purple...Pressure Injury Stage: U (unstageable)... (c.) Wound care consult for sacrum and coccyx wounds. Patient admitted 12/23/19, skin assessment 12/24/19 documented as abrasion, no wound consult entered. Patient had amputation to right lower leg on 12/23/19. Patient in bed, bedside nurse present...patient...states no open area to sacrum/coccyx prior to hospitalization. Sacrum has large purple deep tissue injury measuring 5 x 9.5 cm with small open area to mid coccyx that measures 0.8 x 0.5 cm. Coccyx wound is pale pink and slough covered, unstageable. Mepilex Ag to coccyx wound, cover with sacral border, change			

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	every 3 days..." (G) A review of a nurse note dated 12/27/19 at 3:59 p.m. indicated the following: "...Pt [Patient] c/o [complain of] pain to buttocks after dialysis. 2 open areas noted, along with some dark purple discoloration. Wound care consulted..." H) A physician order dated 12/27/19 at 4:08 p.m. indicated to peel back foam sacral border dressing for skin assessment to start on 12/28/19 at 6:00 a.m. (I) The medical record lacked documentation of skin reassessments of the patient's sacrum wound and/or patient refusing of skin reassessments of sacrum wound every eight hours for the following dates: 12/28/19, 12/29/19 and 12/30/19. 4. During an interview on 9/26/22 at 4:33 p.m., A6 (Registered Nurse/Nursing Director), he/she verified the medical record information for Patients #1, 2, 3, 4 and 5.			