STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150056	A. BUILDING 00 B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

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A 0000 Bldg. 00	This visit was for the investigation of a Federal Hospital Complaint. Complaint Number: IN00446379 - Deficiencies related to the allegations are cited a A0130, A0385, A0395, and A0398. Survey Date: 12/4/2024 & 12/9/2024 Facility Number: 005051 QA: 12/17/2024	A 0000		
A 0130 Bldg. 00	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. Based on document review and interview, facility staff failed to notify a patients family member or POA (Power of Attorney) of a new pressure injury and evolving of an existing pressure injury for 1 of 10 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Patient/Parent Rights and Responsibilities, Complaints and Grievances", no policy number, publication date 06/22/2023, indicated under Your rights as a patient: As a patient of this facility, you have the right: To participate in decisions about care, treatment and services, which may include family and loved ones, as permitted by the patient or decision maker; this includes the development and	A 0130	*Plan of Correction Text:* *Unit leadership educated all RNs on facility policies, and required documentation of Q4H HTA, q2Turns and skin integrity interventions. Education was also provided on building the culture of incident reporting and when pressure injury policy indicates the need to file reports. Unit leadership including (CNS, NPD) developed education materials which also included proper provider notification process and documentation of any new or progression of wound. The unit triad team is re-educating all team*	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Owen		01/29/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	Implementation of an Inpatient treatment or care plan, outpatient treatment or care plan, pain management plan and discharge plan. To be informed of outcomes of care, treatment and services, including unexpected outcomes. 2. Review of P1's MR (Medical Record) indicated the following: Nursing documentation dated 9/15/2024 at 8:00 pm indicated P1's skin was intact with no skin symptoms. On 9/16/2024 P1's skin was assessed at midnight, 4:00 am, and 8:00 am as intact with no skin symptoms. On 9/17/2024 a stage 2 pressure injury, full thickness, red, blisters noted above the pressure ulcer, with erythema was documented as present upon admission at 12:00 pm. Physical Therapy note documentation dated 9/17/2024 at 1:31 pm indicated P1's skin integrity annotation as Per nursing skin auditor N9 (Registered Nurse), patient has a stage 2 pressure injury on sacrum. Physician note documentation dated 9/18/2024 indicated P1's child who is also the patient's POA had a discussion with the medical provider about the patient's disposition and plan of care. P1's skin was documented as warm. This note lacked documentation about a sacral pressure injury. Wound consult note documentation dated 9/18/2024 indicated two wounds were present near the sacrococcygeal area. One more distally which was staged at two and the proximal was staged as a 3. The measurement for this wound was 4.5 x 3.5 cm (centimeters) (Proximal Wound). The distal wound was cleansed, and the zinc barrier cream was applied and left open to air. Wound progress note documentation dated 10/10/2024 indicated P1 developed a deep tissue injury to the left medial great toe over a bunion. This wound measured 2 cm by 2 cm, purple in color, and was intact. P1's sacral stage 3 evolving deep tissue injury present on admission measured 2.5 cm by 3.3 cm, was		*members (RN, PCA, Mobility Techs) on the documentation expectations and reporting changes in patient condition. Education will be provided via Tier 1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. Regulatory leaders will provide education regarding patient, family, and Power of Attorney (POA) notification for unanticipated outcomes (new pressure injury and evolving of an existing pressure injury) as per policy. Education to be completed by 2/14/25.* *Prevent Recurrence:* *• B4 leadership will audit patient charts of individuals with pressure injuries or pressure injury risk and will audit a minimum of 10 patients weekly to validate Q4h head to toe assessments and Q2h turns.* *• • If any wound progressions or new pressure injuries occur on B4, leadership will audit to check if an incident report was filed and will audit the patient chart for provider, patient, and family notification.* *• Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN by unit leadership.* *• Once 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess for policy deviations related to pressure injury documentation.*	

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	yellow and red in color, and had evidence of re-epithelialization. P1's MR lacked nursing reporting skin issues to provider and provider notification to the patients child of ongoing and new pressure injuries. 3. In an interview on 12/4/24 at approximately 2:46 pm am with A2 (Clinical Nurse Specialist) confirmed P1's medical record did not, but should have contained physician notification of advancing staging of P1's stage 2 sacral wound to a stage 3 sacral wound, nor was a provider notified of the new pressure injury to the left medial great toe and should have been. 4. In a telephone interview on 12/4/24 at approximately 2:29 pm with MD1 (Medical Doctor) confirmed he/she wasn't notified by nursing that P1 had a sacral wound nor that P1 developed a new pressure injury on his/her toe. MD1 also confirmed he/she did not recall having a conversation with P1's child regarding these wounds.		*Responsible for Corrective Action:* *• Manager of Clinical Operations* *Completion Date:* *• 2/14/2025.*	
A 0385 Bldg. 00	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. Based on document review and interview, facility nursing staff failed to notify a provider of a new and/or ongoing pressure injuries, failed to document every 2-hour turning and/or repositioning of a patient, and failed to document every 4-hour head-to-toe skin assessments for 1 of 10 medical records reviewed. (P1) See tag A0395.	A 0385	*Plan of Correction Text:* *Unit leadership educated all RNs on facility policies, and required documentation of Q4H HTA, q2Turns and skin integrity interventions. Education was also provided on building the culture of incident reporting and when pressure injury policy indicates the*	02/14/2025

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	The cumulative effects of these systemic problems resulted in the facility's inability to provide nursing care in a safe manner.		*need to file reports. Unit leadership including (CNS, NPD) developed education materials which also included proper provider notification process and documentation of any new or progression of wound. The unit triad team is re-educating all team members (RN, PCA, Mobility Techs) on the documentation expectations and reporting changes in patient condition. Education will be provided via Tier 1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. Regulatory leaders will provide education regarding patient, family, and Power of Attorney (POA) notification for unanticipated outcomes (new pressure injury and evolving of an existing pressure injury) as per policy. Education to be completed by 2/14/25.* *Prevent Recurrence:* *• B4 leadership will audit patient charts of individuals with pressure injuries or pressure injury risk and will audit a minimum of 10 patients weekly to validate Q4h head to toe assessments and Q2h turns.* *• • If any wound progressions or new pressure injuries occur on B4, leadership will audit to check if an incident report was filed and will audit the patient chart for provider, patient, and family notification.* *• Any documentation deficiencies found during the above audit*	

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			process will be reviewed 1:1 with RN by unit leadership. *• Once 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess for policy deviations related to pressure injury documentation.* *Responsible for Corrective Action:* *• Manager of Clinical Operations* *Completion Date:* *• 2/14/2025.*	
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, facility nursing staff failed to notify a provider of a new and/or ongoing pressure injuries, failed to document every 2-hour turning and/or repositioning of a patient, and failed to document every 4-hour head-to-toe skin assessments for 1 of 10 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Escalation of Patient Safety Concerns", no policy number, publication date 03/05/2022, indicated under VI. PROCEDURES: A. The registered nurse (RN) recognizes a change in the patient's condition requiring provider intervention. B. The RN is responsible for communicating changes in the patient's condition that may require specific treatment to the provider and following the attached escalation guides as warranted. (Appendix A)	A 0395	*Plan of Correction Text:* *Unit leadership educated all RNs on facility policies, and required documentation of Q4H HTA, q2Turns and skin integrity interventions. Education was also provided on building the culture of incident reporting and when pressure injury policy indicates the need to file reports. Unit leadership including (CNS, NPD) developed education materials which also included proper provider notification process and documentation of any new or progression of wound. The unit triad team is re-educating all team members (RN, PCA, Mobility Techs) on the documentation expectations and reporting changes in patient condition. Education will be provided via Tier*	02/14/2025

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	2. Facility policy titled, "Documentation Standards", no policy number, publication date 08/05/2024, indicated under V. POLICY STATEMENTS: A. GENERAL DOCUMENTATION STANDARDS. 1 Registered Nurses are accountable for the patient assessment and documentation process. 2. Document assessment parameters pertinent to the patient;s specific condition when the patient's physical assessment/reassessment fall outside of the defined normal limits. 3. Facility standards of care titled, "AAHC Standards of Care for RNs - PCU", no policy number, updated 2024, indicated under Frequency/Task and Minimum Documentation: Q (every) 2 hrs. Vital Signs, Neurological checks, if ordered, Turn, reposition (HOB 30 degrees or greater as applicable, document which side patient is turned, IV access site assessment, Restraints safety checks, Patient safety checks, Toileting, ROM, food/fluid, Pain score if on continuous pain infusion(e.g., Epidural, Ketamine, end-of-life medications), Flap checks, if ordered. Q 4 hrs., Head-to-toe assessment (skin, wounds, drains/tubes, incisions, Document FIO2/delivery source/device, Pain assessment/sedation/POSS, Patient-controlled Epidural anesthesia (PCEA), vital signs Q 4 hrs, HR, RR, SpO2, Signs iAware: review and sign, Intake and output assessment (drains, tubes, feeds, PO), Vital signs, Empty drains and document. 4. Review of P1's MR indicated that Nursing documentation dated 9/15/2024 at 8:00 pm indicated P1's skin was intact with no skin symptoms. On 9/16/2024 P1's skin was assessed at midnight, 4:00 am, and 8:00 am as intact with no skin symptoms. On 9/17/2024 a stage 2 pressure injury, full thickness, red, blisters noted above the		*1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. Regulatory leaders will provide education regarding patient, family, and Power of Attorney (POA) notification for unanticipated outcomes (new pressure injury and evolving of an existing pressure injury) as per policy. Education to be completed by 2/14/25.* *Prevent Recurrence:* *• B4 leadership will audit patient charts of individuals with pressure injuries or pressure injury risk and will audit a minimum of 10 patients weekly to validate Q4h head to toe assessments and Q2h turns.* *• • If any wound progressions or new pressure injuries occur on B4, leadership will audit to check if an incident report was filed and will audit the patient chart for provider, patient, and family notification.* *• Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN by unit leadership.* *• Once 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess for policy deviations related to pressure injury documentation.* *Responsible for Corrective Action:* *• Manager of Clinical Operations* *Completion Date:* *• 2/14/2025.*	

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	pressure ulcer, with erythema was documented as present upon admission at 12:00 pm. Wound consult note documentation dated 9/18/2024 indicated two wounds were present near the sacrococcygeal area. One more distally which was staged at two and the proximal was staged as a 3. The measurement for this wound was 4.5 x 3.5 cm (centimeters) (Proximal Wound). Wound progress noted documentation dated 10/10/2024 indicated P1 developed a deep tissue injury to the left medial great toe over a bunion. This wound measured 2 cm by 2 cm, purple in color, and was intact. P1's sacral stage 3 evolving deep tissue injury present on admission measured 2.5 cm by 3.3 cm, was yellow and red in color, and had evidence of re-epithelialization. P1's MR lacked every 4-hour skin assessments including but not limited to 9/23/24 at 4:00 pm, 9/25/25 at Midnight, and 4:00 am, 9/27/24 at 8:00 pm, and 9/28/2024 at Midnight and 4:00 am, lacked patient turning and/or position changes every 2 hours that included but were not limited to: 9/20/2024 MR as P1's position was indicated as on his/her back, with no documentation of position change or patient refusal noted; 9/25/2024 as P1 was on his/her left side from 6:00 am -6:00 pm no documentation of position change or patient refusal noted; on 9/26/2024 P1 positioned on left side from 6:00 am - 6:00 pm, no documentation of position change or patient refusal noted; 10/13/2024 lacked turning/positioning documentation from 9:00 am to 8:00 pm. P1's MR lacked nursing reporting skin issues to provider. 5. In an interview on 12/4/24 at approximately 2:46 pm am with A2 (Clinical Nurse Specialist) confirmed P1's medical record did not, but should have contained physician notification of			

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	advancing staging of P1's stage 2 sacral wound to a stage 3 sacral wound, nor was a provider notified of the new pressure injury to the left medical great toe and should have been. Confirmed facility nursing staff should have, but did not, document required positioning/turning every 2 hours and every 4-hour skin assessments for P1. 6. In interview on 12/9/2024 at approximately 2:40 pm with N3 (Registered Nurse) confirmed nursing staff are to turn patients every two hours and assess skin every 4 hours. Documentation is to be completed by nursing for both turns and skin assessments.			
A 0398 Bldg. 00	482.23(b)(6) SUPERVISION OF CONTRACT STAFF All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). Based on document review and interview, facility nursing staff failed to complete a significant event report related to pressure injuries for 1 of 10 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Patient Incident and Significant Even Management", no policy number, publication date 09/11/2022, indicated under VI.	A 0398	*Plan of Correction Text:* *Unit leadership educated all RNs on facility policies, and required documentation of Q4H HTA, q2Turns and skin integrity interventions. Education was also provided on building the culture of incident reporting and when pressure injury policy indicates the need to file reports. Unit leadership including (CNS, NPD)*	02/14/2025

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	PROCEDURES: C. Patient Disclosure of Significant Events. When a significant event results in an unanticipated patient outcome, the patient and/or the patient's family should be informed as soon as reasonably possible. The unanticipated patient outcome should be discussed with the family by the attending physician or his or her designee. Prior to discussing the unanticipated outcome with the patient and/or patient's family, the attending physician or designee may consult with Risk Management, hospital administration, or legal counsel. Refer to Patient Disclosure of Serious Clinical Adverse Events for specific information. 2. Review of P1's MR indicated that Nursing documentation dated 9/15/2024 at 8:00 pm indicated P1's skin was intact with no skin symptoms. On 9/16/2024 P1's skin was assessed at midnight, 4:00 am, and 8:00 am as intact with no skin symptoms. On 9/17/2024 a stage 2 pressure injury, full thickness, red, blisters noted above the pressure ulcer, with erythema was documented as present upon admission at 12:00 pm. Wound consult note documentation dated 9/18/2024 indicated two wounds were present near the sacrococcygeal area. One more distally which was staged at two and the proximal was staged as a 3. The measurement for this wound was 4.5 x 3.5 cm (centimeters) (Proximal Wound). Wound progress noted documentation dated 10/10/2024 indicated P1 developed a deep tissue injury to the left medial great toe over a bunion. This wound measured 2 cm by 2 cm, purple in color, and was intact. P1's sacral stage 3 evolving deep tissue injury present on admission measured 2.5 cm by 3.3 cm, was yellow and red in color, and had evidence of re-epithelialization. P1's lacked nursing reporting skin issues to provider.		*developed education materials which also included proper provider notification process and documentation of any new or progression of wound. The unit triad team is re-educating all team members (RN, PCA, Mobility Techs) on the documentation expectations and reporting changes in patient condition. Education will be provided via Tier 1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. Regulatory leaders will provide education regarding patient, family, and Power of Attorney (POA) notification for unanticipated outcomes (new pressure injury and evolving of an existing pressure injury) as per policy. Education to be completed by 2/14/25.* *Prevent Recurrence:* *• B4 leadership will audit patient charts of individuals with pressure injuries or pressure injury risk and will audit a minimum of 10 patients weekly to validate Q4h head to toe assessments and Q2h turns.* *• • If any wound progressions or new pressure injuries occur on B4, leadership will audit to check if an incident report was filed and will audit the patient chart for provider, patient, and family notification.* *• Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN by unit leadership.*	

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	3. Incident Report/Complaint/Grievance log were reviewed for the months of 6/1/24-12/1/24. P1 was listed on the incident log on 10/9/2024 in relation to developing a hospital acquired pressure injury to his/her left great toe. This incident report lacked physician notification and family notification. Review of incident reports lacked documentation of P1 sacral pressure injury and family notification of this pressure injury. 4. In an interview on 12/4/24 at approximately 2:46 pm am with A2 (Clinical Nurse Specialist) confirmed P1's medical record did not but should have contained physician notification of advancing staging of P1's stage 2 sacral wound to a stage 3 sacral wound, nor was a provider notified of the new pressure injury to the left medical great toe and should have been.		*• Once 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess for policy deviations related to pressure injury documentation.* *Responsible for Corrective Action:* *• Manager of Clinical Operations* *Completion Date:* *• 2/14/2025.*	
S 0000 Bldg. 00	This visit was for the investigation of a State Licensure hospital Complaint. Complaint Number: IN00446379- Deficiency related to the allegations is cited at S0930. Survey Dates: 12/4/2024 & 12/9/2024. Facility Number: 005051 QA: 12/17/2024	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			

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	following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, facility nursing staff failed to file incident reports and notify a provider of new or ongoing pressure injuries (P1), failed to document every 2-hour turning and/or repositioning of a patient (P1), and failed to document every 4-hour head-to-toe skin assessments for 1 of 10 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Escalation of Patient Safety Concerns", no policy number, publication date 08/05/2024, indicated under VI. PROCEDURES: A. The registered nurse (RN) recognizes a change in the patient's condition requiring provider intervention. B. The RN is responsible for communicating changes in the patient's condition that may require specific treatment to the provider and following the attached escalation guides as warranted. (Appendix A) 2. Facility policy titled, "Documentation Standards", no policy number, publication date 08/05/2024, indicated under V. POLICY STATEMENTS: A. GENERAL DOCUMENTATION STANDARDS. 1 Registered Nurses are accountable for the patient assessment and documentation process. 2. Document assessment parameters pertinent to the patient;s specific condition when the patient's physical assessment/reassessment fall outside of the defined normal limits.	S 0930	*Plan of Correction Text:* *Unit leadership educated all RNs on facility policies, and required documentation of Q4H HTA, q2Turns and skin integrity interventions. Education was also provided on building the culture of incident reporting and when pressure injury policy indicates the need to file reports. Unit leadership including (CNS, NPD) developed education materials which also included proper provider notification process and documentation of any new or progression of wound. The unit triad team is re-educating all team members (RN, PCA, Mobility Techs) on the documentation expectations and reporting changes in patient condition. Education will be provided via Tier 1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. Regulatory leaders will provide education regarding patient, family, and Power of Attorney (POA) notification for unanticipated outcomes (new pressure injury and evolving of an existing pressure injury) as per policy. Education to be completed by 2/14/25.* *Prevent Recurrence:*	02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING 00 B. WING	12/09/2024

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	3. Facility standards of care titled, "AAHC Standards of Care for RNs - PCU", no policy number, updated 2024, indicated under Frequency/Task and Minimum Documentation: Q 2 hrs. Vital Signs, Neurological checks, if ordered, Turn, reposition (HOB 30 degrees or greater as applicable, document which side patient is turned, IV access site assessment, Restraints safety checks, Patient safety checks, Toileting, ROM, food/fluid, Pain score if on continuous pain infusion(e.g., Epidural, Ketamine, end-of-life medications), Flap checks, if ordered. Q 4 hrs., Head-to-toe assessment (skin, wounds, drains/tubes, incisions, Document FIO2/delivery source/device, Pain assessment/sedation/POSS, Patient-controlled Epidural anesthesia (PCEA), vital signs Q 4 hrs, HR, RR, SpO2, Signs iAware: review and sign, Intake and output assessment (drains, tubes, feeds, PO), Vital signs, Empty drains and document. 4. Facility policy titled, "Patient Incident and Significant Even Management", no policy number, publication date 09/11/2022, indicated under VI. PROCEDURES: C. Patient Disclosure of Significant Events. When a significant event results in an unanticipated patient outcome, the patient and/or the patient's family should be informed as soon as reasonably possible. The unanticipated patient outcome should be discussed with the family by the attending physician or his or her designee. Prior to discussing the unanticipated outcome with the patient and/or patient's family, the attending physician or designee may consult with Risk Management, hospital administration, or legal counsel. Refer to Patient Disclosure of Serious Clinical Adverse Events for specific information. 5. Review of P1's MR indicated that Nursing		*• B4 leadership will audit patient charts of individuals with pressure injuries or pressure injury risk and will audit a minimum of 10 patients weekly to validate Q4h head to toe assessments and Q2h turns.* *• • If any wound progressions or new pressure injuries occur on B4, leadership will audit to check if an incident report was filed and will audit the patient chart for provider, patient, and family notification.* *• Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN by unit leadership.* *• Once 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess for policy deviations related to pressure injury documentation.* *Responsible for Corrective Action:* *• Manager of Clinical Operations* *Completion Date:* *• 2/14/2025.*	

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	documentation dated 9/15/2024 at 8:00 pm indicated P1's skin was intact with no skin symptoms. On 9/16/2024 P1's skin was assessed at midnight, 4:00 am, and 8:00 am as intact with no skin symptoms. On 9/17/2024 a stage 2 pressure injury, full thickness, red, blisters noted above the pressure ulcer, with erythema was documented as present upon admission at 12:00 pm. Wound consult note documentation dated 9/18/2024 indicated two wounds were present near the sacrococcygeal area. One more distally which was staged at two and the proximal was staged as a 3. The measurement for this wound was 4.5 x 3.5 cm (centimeters) (Proximal Wound). Wound progress noted documentation dated 10/10/2024 indicated P1 developed a deep tissue injury to the left medial great toe over a bunion. This wound measured 2 cm by 2 cm, purple in color, and was intact. P1's sacral stage 3 evolving deep tissue injury present on admission measured 2.5 cm by 3.3 cm, was yellow and red in color, and had evidence of re-epithelialization. P1's MR lacked every 4-hour skin assessments including but not limited to 9/23/24 at 4:00 pm, 9/25/25 at Midnight, and 4:00 am, 9/27/24 at 8:00 pm, and 9/28/2024 at Midnight and 4:00 am, lacked patient turning and/or position changes every 2 hours that included but were not limited to: 9/20/2024 MR as P1's position was indicated as on his/her back, with no documentation of position change or patient refusal noted; 9/25/2024 as P1 was on his/her left side from 6:00 am -6:00 pm no documentation of position change or patient refusal noted; on 9/26/2024 P1 positioned on left side from 6:00 am - 6:00 pm, no documentation of position change or patient refusal noted; 10/13/2024 lacked turning/positioning documentation from 9:00 am to 8:00 pm. P1's MR lacked nursing reporting skin issues to provider.			

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	6. Incident Report/Complaint/Grievance log were reviewed for the months of 6/1/24-12/1/24. P1 was listed on the incident log on 10/9/2024 in relation to developing a hospital acquired pressure injury to his/her left great toe. This incident report lacked physician notification and family notification. Review of incident reports lacked documentation of P1 sacral pressure injury and family notification of this pressure injury. 7. In an interview on 12/4/24 at approximately 2:46 pm am with A2 (Clinical Nurse Specialist) confirmed P1's medical record did not but, should have contained physician notification of advancing staging of P1's stage 2 sacral wound to a stage 3 sacral wound, nor was a provider notified of the new pressure injury to the left medical great toe and should have been. Confirmed facility nursing staff should have, but did not, document required positioning/turning every 2 hours and every 4-hour skin assessments for P1. 8. In interview on 12/9/2024 at approximately 2:40 pm with N3 (Registered Nurse) confirmed nursing staff are to turn patients every two hours and assess skin every 4 hours. Documentation is to be completed by nursing for both turns and skin assessments.			