

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
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S 0000  Bldg. 00	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint Number: IN00186622</p> <p>Substantiated; deficiencies related to allegations are cited</p> <p>Date of survey: 12/16/15 through 12/17/15</p> <p>Facility number: 005051</p> <p>QA: cjl 12/23/15</p>	S 0000		
S 0732  Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on document review and</p>	S 0732	<b>S732 15-1.5-4 MedicalRecord</b>	02/15/2016

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>interview, the medical staff failed to write orders for wound vacuum (VAC) care and failed to include orders for wound VAC care upon discharge for 1 of 10 patients (patient #1), failed to complete a medication reconciliation per policy for 6 of 10 patients (patients #1, 5, 6, 8, 9 and 10) resulting in delay of seizure medication administration for 1 of 10 patients (patient #1).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of policy/procedure titled "CONTENT OF MEDICAL RECORDS" last reviewed/revised 2/28/15 indicated the following: Page 1: "The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care among health care providers. The patient's medical record includes written, transcribed, and electronic information, and .....". Page 2 states under attending physician: "Documentation responsibilities of the attending physician include: 1. Progress notes, operative notes, and/or orders which reflect the management of the patient's care;....."</li> <li>Review of policy/procedure titled "MEDICATION RECONCILIATION"</li> </ol>		<p><b>Services</b> The medical staff failed to write orders for wound vacuum(VAC) care, failed to include orders for wound VAC care upon discharge, and failed to complete medication reconciliation per policy resulting in delay of seizure medication administration.</p> <p><b>Corrective Action(s):</b> The ten medical records investigated during the complaint were reviewed and validated by the Medical Staff Office Specialist, Medical Staff Quality and Peer Review on Wednesday, December 30 and Thursday, December 31, 2015. Education on admission medication reconciliation and wound vacuum management will be included in the <i>eNews for Docs</i> newsletter (provider newsletter) sent to all IU Health AHC Providers on January 25, 2016. A mass educationale-mail regarding admission medication reconciliation was sent to providers on January 13, 2016. By January 18, 2016, the IU Health AHC Adult Hospitals CMO and the Medical Director of Inpatient Medicine, with the assistance of the IU Health Wound Care Team will provide education to the staff physician and physician assistant that were overseeing this patient's care. These providers will be given information regarding the availability of a negative pressure wound therapy (NPWT)</p>	

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	<p>last reviewed/revised 6/30/13 indicated the following: Page 3: "D. A good faith effort for the Medication History is best performed as early in the encounter as possible, no later that 24 hours after inpatient admission.....F. Medication Reconciliation is a dynamic process and ultimately the responsibility of the prescriber. G. Medication Reconciliation will be done upon all transitions in care as defined above."</p> <p>3. Review of patient #1's medical record, on 12/16/15, for the first visit, indicated the following:</p> <p>(A) He/she was admitted to the facility on 10/6/15 at 0921 hours due to post operative bleeding from surgical site where a Baclofen pump had been placed on 10/5/15.</p> <p>(B) The patient's home medications listed on the emergency department (ED) physician progress note included, but was not limited to, Depakene (for seizures) 400 milligrams (mg) three times a day (TID) and Phenobarbital 40 mg every a.m. and 60 mg every evening.</p> <p>(C) The Physician Progress Note for the ED indicated the patient had seizure activity in the ED and was treated with Ativan.</p> <p>(D) Per nurse notes, the patient had seizure activity and increased heartrate at 1334 hours on 10/7/15, which was</p>		<p>protocol orders that address what type of NPWT device isto be used, device suction (negative pressure) requirements, designate who isresponsible for wound care (wound team, physical therapy wound management team,or physician name/team/service), dressing types to be used, and frequency ofdressing changes. This information is tobe provided by Friday, January 15, 2016. The staff physician and physician assistantwill also receive education on tailoring discharge instructions to meet theindividual patient needs, including wound vacuum management.</p> <p>The case manager that was assigned to the patient with thewound vacuum was formally counseled on December 18, 2015 on proper casemanagement documentation.</p> <p><b>Monitoring:</b></p> <p>To ensure compliance, beginning February 2016, the MedicalStaff Office Specialist, Medical Staff Quality and Peer Review will initiate amonthly audit of thirty (30) patient records at IUH Methodist Hospital. The audit will include monitoring ofadmission medication reconciliation completion on inpatients. The audit results will be shared with the attendingproviders. . This audit will be completed for three months,with expectations for 90% compliance or greater. If this threshold is achieved, then</p>				

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	<p>reported, with orders to continue to monitor the patient. The medication reconciliation was not completed until 1528 hours on 10/7/15. Review of orders indicated the seizure medications were ordered on 10/7/15 at 1530 hours. There was no explanation in the medical record as to why the medication reconciliation was delayed or seizure medications not ordered upon admission.</p> <p>4. Review of patient #1's medical record, on 12/16/15, for visit #3, indicated the following:</p> <p>(A) The patient presented to the ED at 0040 on 11/1/15 for pump malfunction and fever for several days.</p> <p>(B) The patient had surgery on 11/2/15 to replace the Baclofen pump from the right side to the left side. Per the operative note, a wound VAC was placed in the right surgical wound site after incision and drainage. The medical record lacked an order for care/maintenance of the wound VAC. Physician progress notes indicated the patient had the wound VAC, however there was no care to the wound itself documented.</p> <p>(C) The patient was discharged back to facility #2 on 11/10/15. The discharge instructions lacked instructions/orders related to the wound VAC. The discharge instructions lacked</p>		<p>theauditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, thenconsistent auditing will continue until such time that data for a consecutivethree month period reflects achievement of the 90% threshold. Results of audits will be analyzed and trendedthrough the Medical Staff Quality and Performance Review Committee.</p> <p><b>ResponsiblePerson(s):</b> The IU Health Academic Health Center – Adult Hospitals ChiefMedical Officer, the Medical Director of Inpatient Medicine of IU HealthMethodist Hospital and the Medical Staff Office Specialist, Medical StaffQuality and Peer Review will be responsible for ensuring that providers have a clearunderstanding of expectations related to medication reconciliation, woundvacuum management, and monitoring of these corrective actions to ensure thedeficiency is corrected and will not recur.</p>		

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	<p>documentation that the patient had a wound VAC.</p> <p>(D) Review of case management progress note dated 11/3/15 at 1558 hours states "will follow up as .....to identify potential needs....." There were notes dated 11/4/15, 11/5/15, and 11/6/15 with basically the same information in each note and no potential needs identified. Case management note dated 11/10/15 at 1701 hours indicated the patient was to discharge to facility #2 via ambulance. The notes lacked evidence that arrangements had been made for a wound VAC at facility #2 for the patient.</p> <p>5. Review of patient #5's medical record on 12/16/15 indicated the following: (A) He/she was admitted on 10/6/15. (B) The medical record lacked evidence that a medication reconciliation was completed.</p> <p>6. Review of patient #6's medical record on 12/17/15 indicated the patient was admitted 12/4/15. The medication reconciliation was not completed by the practitioner until 12/7/15.</p> <p>7. Review of patient #8's medical record on 12/17/15 indicated the patient was admitted 12/14/15. The medical record lacked evidence that the medication reconciliation was completed.</p>			

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	<p>8. Review of patient #9 medical record on 12/17/15 indicated the patient was admitted 12/15/15. The medical record lacked evidence that the medication reconciliation was completed.</p> <p>9. Review of patient #10's medical record on 12/17/15 indicated the following: (A) The patient was admitted on 12/14/15. (B) The medical record lacked evidence that a medication reconciliation was completed by the practitioner.</p> <p>10. Staff member #18 (Director of Nursing at facility #2) indicated in phone interview beginning at 12:55 p.m. on 12/16/15 that patient #1 had wound VAC sponge frozen and stuck upon arrival to their facility and it took a couple days to get it out. He/she indicated there was no wound VAC sent with the patient.</p> <p>11. Staff member #19 (Unit Manager at facility #2) indicated in phone interview beginning at 12:58 p.m. on 12/16/15 that patient #1 arrived with no orders for a wound VAC and there was a wound VAC sponge in a wound covered by a clear dressing. He/she indicated there was nothing in the paperwork about the wound VAC. He/she indicated there was</p>			

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	<p>"greenish pus" in the wound after the sponge was removed. The patient's pediatrician was notified and looked at the wound. The patient was sent to wound care.</p> <p>12. Medical record information for patients #1-5 was verified by staff member #4 (Accreditation Specialist) beginning at 1:30 p.m. on 12/16/15.</p> <p>13. Medical record information for patients #6-10 was verified by staff member #5 (Information Systems Clinical Manager) beginning at 11:00 a.m. on 12/17/15.</p> <p>14. Staff member #20 (registered nurse [RN] wound therapy nurse) indicated in interview beginning at 12:30 p.m. on 12/17/15 that a wound VAC dressing change would typically be three (3) times a week on Monday, Wednesday, and Friday. He/she indicated that the wound therapy department is notified of the need for wound care through an order to change dressings or an order for wound VAC power plan which is entered by the physician. He/she verified that there was no wound care orders or wound VAC power plan entered by the physician for patient #1.</p>			

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S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(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</p>			

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	<p>personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.</p> <p>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the nurse executive failed to establish the standards of care by failing to ensure nurses followed followed physician orders for 8 of 10 patients (patients #1-5 and 8-10), failed to complete pain assessments per policy for 3 of 10 patients (patient #1, 2 and 9) and failed to provide medications per order to 1 of 10 patients (patients #5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of policy/procedure titled "PAIN MANAGEMNT" last reviewed/revised 11/30/14 indicated the following on page 5: ".....3. Ongoing nursing assessment for the presence or absence of pain is completed by an RN (registered nurse) a minimum of every shift or more often as patient condition warrants."</li> <li>The RN job description indicated the following under clinical judgement: ".....Accurately communicates patient information and thoroughly documents</li> </ol>	S 0912	<p><b>S912 15-1.5-6 NursingService</b></p> <p>The nurse executive failed to establish the standards of care by failing to ensure nurses followed physician orders, failed to complete pain assessments per policy and failed to provide medications per order.</p> <p><b>Corrective Action(s):</b></p> <p>The IUH Methodist Clinical Manager on A5S began discussion of wounds and wound vacuum in unit daily huddles on Monday, January 4, 2016. By January 31, 2016, all A5S nursing staff will be educated on the following:</p> <ol style="list-style-type: none"> <li>Wound vacuum management</li> <li>Pain assessment expectations including opioid tolerance level education sessions and pain assessment requirements</li> <li>Documentation of clinical variance and notification to physicians of that variance related to call orders</li> <li>PRN medication administration</li> </ol> <p>The education with all A5S nursing staff will be conducted via email, PowerPoint, and A5S unit</p>	01/31/2016

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	<p>nursing actions and plan of care...."</p> <p>3. Review of patient #1's medical record for the first visit indicated the following:</p> <p>(A) He/she was admitted to the facility on 10/6/15 at 0921 hours due to post operative bleeding from surgical site where a Baclofen pump had been placed on 10/5/15.</p> <p>(B) Orders were written on 10/6/15 at 1321 hours to call M.D. (Medical Doctor) if heartrate was &gt;120 or &lt;50 or O2 sat &lt; 90.</p> <p>(C) Per clinical assessments flowsheet, the patient had two (2) episodes of heart rate &gt;120. The documentation indicated he/she had a heart rate of 127 at 12:00 on 10/7/15 and a heart rate of 136 at 2000 hours on 10/7/15. The medical record lacked documentation that the physician was notified per order of the increased heartrate of 127 or 136. Review of the medical record indicated that the physician was notified of family member #1's concerns about discharge and increased heartrate, however this notification was at 1829 hours on 10/7/15 and prior to the episode of an increased heartrate of 136.</p> <p>(D) Pain assessments were not completed per facility policy. There was no pain assessment completed for the 7:00 p.m. to 7:00 a.m. shift on 10/6/15 and 7:00 am. to 7:00 p.m. shift on</p>		<p>huddles. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work.</p> <p><b>Monitoring:</b> To ensure compliance, beginning January 15, 2016, IUH Methodist Clinical Manager on A5Swill initiate a monthly audit of thirty (30) patient records. The audit will include monitoring of documentation related to pain assessments, appropriate documentation of clinical variance and notification to physicians of that variance, e.g. blood pressure call order, and prn medication administration. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in unit quality display boards and analyzed and trended through the unit Professional Practice Council. To confirm compliance on other</p>	

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	<p>10/7/15. The section for the patient's pain score was left blank from 1700 hours on 10/6/15 through 2000 hours on 10/7/15.</p> <p>4. Review of patient #1's medical record for visit #3 indicated the following: (A) The patient presented to the ED (emergency department) at 0040 on 11/1/15 for pump malfunction and fever for several days. (B) An order was written at 0355 on 11/1/15 to call M.D. if heart rate &gt;120 or &lt;50, O2 sat &lt;90%, or systolic blood pressure &gt;180 or &lt;90. The patient had a heart rate of 124 at 0632 hours on 11/3/15 and 126 at 10:00 on 11/3/15. The medical record lacked documentation that the physician was notified per order. (C) The medical record lacked documentation that pain assessments were completed per policy. There was no pain assessment documented for dayshift on 11/1/15 and 11/6/15.</p> <p>5. Review of patient #2's medical record indicated the following: (A) He/she was admitted on 10/4/15. (B) An order was written at 1533 hours on 10/4/15 to call M.D. if systolic blood pressure &lt;90 or &gt;180, diastolic blood pressure &gt;95, or heart rate &lt;55 or &gt;120. (C) The medical record indicated the</p>		<p>units, beginning January 15, 2016, IUH Methodist ClinicalManagers will initiate a monthly audit of eight (8) patient records. The audit will include monitoring ofdocumentation related to pain assessments and appropriate documentation ofclinical variance and notification to physicians of that variance, e.g. bloodpressure call order. Any identified gapswill immediately be discussed with the staff on an individual basis forperformance improvement. This audit willbe completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then theauditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, thenconsistent auditing will continue until such time that data for a consecutivethree month period reflects achievement of the 90% threshold. Results of audits will be included in unitquality display boards and communicated through the unit Professional PracticeCouncils. Monthly hospital widecompliance will be shared at house-wide Professional Practice Council.</p> <p><b>ResponsiblePerson(s):</b> Vice President andChief Nursing Officer for IU Health Academic Health Center Adult Hospitals andthe IU Health Methodist Associate Chief Nursing Officer will be responsible foroversight.</p>		

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	<p>patient's blood pressure was 89/55 at 1600 hours on 10/5/15, 140/111 at 0500 hours on 10/7/15, and 178/100 at 2300 hours on 10/10/15. The medical record lacked documentation that the physician was notified per order of the vital signs. (D) The medical record lacked documentation of a pain assessment on dayshift on 10/9/15.</p> <p>6. Review of patient #3's medical record indicated the following: (A) He/she was admitted to facility on 10/6/15. (B) An order was written on 10/6/15 to call M.D. if systolic blood pressure &gt;140 or &lt;90 or heart rate &gt;120 or &lt;60. (C) The medical record indicated the patient had a heart rate of 59 at 0200 hours on 10/7/15, 58 at 0400 hours on 10/7/15, 57 at 0800 hours on 10/7/15, 50 at 0200 hours on 10/8/15, 56 at 0400 hours on 10/8/15, 58 at 0600 hours on 10/8/15, 51 at 12:00 on 10/8/15, 50 at 0000 hours on 10/9/15, 49 at 0200 hours on 10/9/15, 50 at 0400 hours on 10/9/15, and 48 at 0600 hours on 10/9/15. His/her blood pressure was 150/66 at 0000 hours on 10/8/15, 147/66 at 0200 hours on 10/8/15, 147/118 at 2200 hours on 10/8/15, 146/65 at 0000 hours on 10/9/15, 154/68 at 0200 hours on 10/9/15, 155/67 at 0400 hours on 10/9/15, 168/69 at 0600 hours on</p>		<p>IU Health Methodist Clinical Director of the Surgical Division along with the Clinical Managers of A5S will be responsible for ensuring that staff has a clear understanding of monitoring of these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>10/9/15. The medical record lacked documentation that the physician was notified of the vital signs per order.</p> <p>7. Review of patient #4's medical record indicated the following: (A) He/she was admitted on 10/8/15. (B) An order was written at 0500 hours on 10/8/15 to call M.D. of systolic blood pressure &gt;180 or &lt;90, diastolic blood pressure &gt;100 or &lt;50, or heart rate &lt;50 or &gt; 120. (C) The medical record indicated that the patient's blood pressure was 163/49 at 11:02 on 10/8/15 and 145/45 at 1406 hours on 10/8/15. The medical record lacked documentation that the physician was notified of the vital signs per order.</p> <p>8. Review of patient #5's medical record indicated the following: (A) He/she was admitted on 10/6/15. (B) An order was written at 1500 hours on 10/6/15 to call M.D. of systolic blood pressure &gt;180 or &lt;90, diastolic blood pressure &gt;100 or &lt;50, or heart rate &gt;120 or &lt;50. The medical record indicated the patient's blood pressure was 200/109 at 2200 hours on 10/6/15. The physician was notified and orders received for Labetalol 20 mg IV push every 2 hours prn (as needed) and Hydralazine 20 mg IV push every 2 hours prn; both blood pressure medications. The record</p>						

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	<p>indicated his/her blood pressure was 214/107 at 0400 hours on 10/7/15, 173/108 at 0600 hours on 10/7/15, 202/103 at 0703 hours on 10/7/15, 161/102 at 1400 hours on 10/7/15, 186/98 at 0736 hours on 10/8/15, 150/126 at 0800 hours on 10/8/15, 141/106 at 0600 hours on 10/9/15, and 131/112 at 11:30 on 10/8/15 with a heart rate of 127 at 11:30 on 10/18/15. The medical record lacked documentation that the physician was notified of the vital signs per order. Additionally, the medical record lacked documentation that the prn medication was administered for the high blood pressure at 1400 hours on 10/7/15, 0800 hours on 10/8/15, and 0600 hours on 10/9/15.</p> <p>9. Review of patient #8's medical record indicated the following: (A) An order was written at 1642 hours on 12/14/15 to call with heart rate &gt;130 or &lt; 60. The order was changed at 2017 hours on 12/15/15 to call if heart rate &gt;120. The medical record indicated the patient's heart rate was 123 at 1300 hours on 12/16/15, 127 at 1400 hours on 12/16/15, 135 at 1429 hours on 12/16/15, 132 at 1500 hours on 12/16/15, 127 at 2000 hours on 12/16/15, and 121 at 2200 hours on 12/16/15. The medical record lacked documentation that the physician was notified of the increased heart rate</p>			

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	<p>per order.</p> <p>10. Review of patient #9's medical record indicated the following: (A) An order was written at 0226 hours on 12/16/15 to call M.D. for heart rate &gt; 120 or &lt; 50. The medical record indicated the patient's heart rate was 138 at 0800 hours on 12/16/15, 134 at 1200 on 12/16/15, 137 at 1600 hours on 12/16/15, 141 at 2257 hours on 12/16/15, 140 at 2306 hours on 12/16/15, 144 at 0200 hours on 12/17/15, and 123 at 0400 hours on 12/17/15. The medical record lacked documentation that the physician was notified of the increased heart rate per order. (B) The medical record lacked documentation of a pain assessment on dayshift on 12/16/15.</p> <p>11. Review of patient #10's medical record indicated the following: (A) The patient was admitted on 12/14/15. (B) An order was written at 0549 hours on 12/14/15 to call M.D. if systolic blood pressure &gt;160 or &lt;90 and diastolic blood pressure &gt;110 or &lt;50. The medical record indicated the patient's blood pressure was 85/56 at 0700 hours on 12/14/15, 71/49 at 0800 hours on 12/14/15, 83/55 at 10:00 on 12/14/15, 167/75 at 2100 hours on 12/15/15, and</p>						

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S 0932 Bldg. 00	<p>179/106 at 0400 hours on 12/16/15. The medical record lacked documentation that the physician was notified of the abnormal blood pressures per order.</p> <p>12. Medical record information for patients #1-5 was verified by staff member #4 (Accreditation Specialist) beginning at 1:30 p.m. on 12/16/15.</p> <p>13. Medical record information for patients #6-10 was verified by staff member #5 (Information Systems Clinical Manager) beginning at 11:00 a.m. on 12/17/15.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p>			

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	<p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review and interview, the nursing staff failed to include surgical site and wound vacuum (VAC) in the patient's care plan for 1 of 10 patients (patient #1).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the registered nurse (RN) job description indicated the following under clinical judgement: "...develops, implements then evaluates the patient's (known error) individualized plan of care; and modifies plan to meet mutually agreed-upon clinical outcomes..."</li> <li>Review of patient #1's medical record for visit #3 indicated the following:               <ol style="list-style-type: none"> <li>The patient presented to the emergency department (ED) at 0040 on 11/1/15 for pump malfunction and fever for several days.</li> <li>The patient had surgery on 11/2/15 to replace the Baclofen pump from the right side to the left side. Per the operative note, a wound VAC was placed in the right surgical wound site after an incision and drainage.</li> <li>The patient's incision and wound VAC were not part of the patient's care plan.</li> </ol> </li> </ol>	S 0932	<p><b>S932 15-1.5-6 Nursing Service</b></p> <p>The nursing staff failed to include surgical site and wound vacuum in the patient's care plan.</p> <p><b>Corrective Action(s):</b></p> <p>By January 31, 2016 the IUH Methodist A5S Clinical Manager will provide education to all A5S nursing staff on PPOC (patient plan of care) related to wounds and wound vacuum. The education with all A5S nursing staff will be conducted via email, PowerPoint, and A5S unit huddles. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work.</p> <p><b>Monitoring:</b></p> <p>To ensure compliance, beginning January 15, 2016, Methodist Clinical Manager on A5S will initiate a monthly audit of thirty (30) patient records. The audit will include monitoring of documentation related to care planning. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot</p>	01/31/2016

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	3. Medical record information for patient #1 was verified by staff member #4 (Accreditation Specialist) beginning at 1:30 p.m. on 12/16/15.		audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in unit quality display boards and analyzed and trended through the unit Professional Practice Council. To confirm compliance on other units, beginning January 15, 2016, IUH Methodist Clinical Managers will initiate a monthly audit of eight (8) patient records. The audit will include monitoring of documentation related to care planning. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in unit quality display boards and communicated through the unit Professional Practice Councils. Monthly hospital wide compliance will be shared at house-wide	

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S 1318 Bldg. 00	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW &amp; DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C) (D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on document review and interview, the facility failed to transfer patients with appropriate information for follow-up</p>	S 1318	<p>Professional Practice Council. <b>Responsible Person(s):</b> IU Health MethodistClinical Director of the Surgical Division along with the Clinical Managers ofA5S will be responsible for ensuring that staff has a clear understanding of monitoring of these corrective actions to ensure the deficiency is corrected and will not recur.</p> <p><b>S1318 15-1.5-10 Utilization Review and Discharge Planning</b> The facility failed to transfer patients with appropriate</p>	02/15/2016	

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	<p>care for 1 of 10 patients (patient #1).</p> <p>Findings include:</p> <p>1. Review of policy/procedure titled "CONTENT OF MEDICAL RECORDS" last reviewed/revised 2/28/15 indicated the following on page 1: "The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care among health care providers....."</p> <p>2. Review of policy/procedure titled "INTEGRATED CARE MANAGEMENT PROCESS" last reviewed/revised 9/14 indicated the following: V. Policy Statements: "A. Integrate Care Management (ICM) is a system-wide, interdisciplinary department that plans, organizes and provides health care services.....The purpose of ICM is to achieve the following 5. Develop safe discharge plan for transition through the health care continuum...."</p> <p>3. Review of policy/procedure titled "DISCHARGE PLANNING" effective 7/31/14 indicated the following on page 2: "The discharge planning process will: A. Facilitate the transfer of the patient</p>		<p>information for follow-up care.</p> <p><b>Corrective Action(s):</b> The case manager that was assigned to the patient with thewound vacuum was formally counseled on December 18, 2015 on proper casemanagement documentation. The Director for Integrate Case Management at IUH Methodistand University Hospital reviewed the following policies: ADM 1.04 Content of Medical Records, ICM 1.00Integrated Care Management Process, and ICM 2.05 Discharge Planning to ensure they met the required standards of practice. By February 15, 2016 the Director for Integrated Case Management will provide re-education and emphasis to all Case Managers on the above listed policies inreference to appropriate case management documentation in a patient' s medicalrecord. The coordination of dischargeequipment will be included in the re-education. Any staff required to complete the outlined education that is presentlyon an approved leave will be required to complete this task on an individualbasis upon returning to work. On December 18,2015 the Program Director for IUH Care Alliance Services reviewed the followingwith the Care Alliance Referral Liaisons: 1.Standard list of attachments that are to be sent with a new or</p>	

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	<p>from one level of care to another while maintaining the continuity of care (hospital to post acute )..... Oversight of this collaborative process assures that each patient and family will: ....B. Experience a smooth and safe transition between the various levels and/or areas of patient care..... D. Experience a timely development and implementation of a discharge evaluation and plan based upon the appropriate needs." Page 4 of 6 states "I. The discharge plan may include but is not limited to referrals for Durable Medical Equipment.....J. Necessary medical information will be provided for patients transferred to another inpatient facility or agency for post acute care needs at the time of transfer to the accepting facility/agency."</p> <p>4. Review of policy/procedure titled "USE OF ALLSCRIPTS (ECIN) FOR DISCHARGE PLANNING last reviewed/revised 7/14 indicated the following on page 5: "H. Post Acute Facility Transition Packet contents (sent with referral) 1. Transition Document 2. PAS paperwork (sent with patient) 3. 5 day MAR 5. Consult notes 6. Rounds notes 7. Admission H/P or 1st progress note containing patient history 8. Chest x-ray (admit and most recent) 9. Most recent progress notes (each discipline) 10. Most recent therapy notes (all</p>		<p>return referral to a post-acute facility</p> <p>2. In the event of an after-hours or weekend discharge forwarded by the on call Referral Liaison, the assigned Referral Liaison is to review the documents sent with the referral during the next business day to ensure that all appropriate and available documents have been sent The Program Director for IUH Care Alliance Services will review the above information against monthly rounding in January to reinforce and validate understanding. The staff physician and physician assistant will also be educated on including wound vacuum management in the patient's discharge instructions.</p> <p><b>Monitoring:</b> To ensure compliance, beginning February 15, 2016, the Director of Integrated Case Management will initiate a monthly audit of thirty (30) patient records. The audit will assess completeness of documentation by the Case Manager. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced</p>	

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	<p>therapies) 11. Nursing notes with wound information 12. Copy of insurance card, if available. 13. Discharge instructions (sent with patient).</p> <p>5. Review of patient #1's medical record for visit #3 indicated the following:                      (A) The patient presented to the emergency department (ED) at 0040 on 11/1/15 for pump malfunction and fever for several days.                      (B) The patient had surgery on 11/2/15 to replace the Baclofen pump from the right side to the left side. Per the operative note, a wound vacuum (VAC) was placed in the right surgical wound site after incision and drainage.                      (C) The patient was discharged back to facility #2 on 11/10/15. The discharge instructions lacked instructions/orders related to the wound VAC. The discharge instructions lacked documentation that the patient had a wound VAC.                      (D) Case management note dated 11/10/15 at 1701 hours indicated the patient was to discharge to facility #2 via ambulance. The notes lacked documentation that arrangements had been made for a wound VAC at facility #2 for the patient.</p> <p>6. Staff member #19 (Unit Manager at facility #2) indicated in phone interview</p>		<p>threshold isnot met, then consistent auditing will continue until such time that data for aconsecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in monthlstaff meetings.</p> <p><b>Responsible Person(s):</b> The Director ofIntegrated Case Management will be responsible for ensuring that staff has aclear understanding of monitoring of these corrective actions to ensure thedeficiency is corrected and will not recur.</p>	

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	<p>beginning at 12:58 p.m. on 12/16/15 that patient #1 arrived with no orders for a wound VAC and there was a wound VAC sponge in a wound covered by a clear dressing. He/she indicated there was nothing in the paperwork about the wound VAC.</p> <p>7. Medical record information for patients #1-5 was verified by staff member #4 (Accreditation Specialist) beginning at 1:30 p.m. on 12/16/15.</p> <p>8. Staff member #22, registered nurse (RN) charge nurse, indicated in interview beginning at 1:05 p.m. on 12/17/15 that nursing follows physician orders related to care of a patient with a wound VAC.</p> <p>9. Staff member #8 (Case Manager for patient #1) indicated in interview beginning at 1:10 p.m. on 12/17/15 that the process for referral includes sending progress notes, clinical vital sign sheets, chart summary to Indiana University Care Alliance (IU CAS) and they send it to the facility. The physician is in charge of discharge instructions. He/she has no evidence that facility #2 was notified that patient #1 had a wound VAC or orders related to such.</p> <p>10. Staff member #23 (M.D.) indicated in interview beginning at 1:25 p.m. on</p>			

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	<p>12/17/15 that the physicians put in an order for wound team to consult and that the paperwork that goes with the patient at time of discharge would include wound VAC instructions and this is usually entered by the wound team.</p> <p>11. Staff member #25 (RN Director of Integrated Care Management) indicated in interview beginning at 2:15 p.m. on 12/17/15 that information is sent to the receiving facility through Care Alliance and that tracking of the Care Alliance communications is not part of the medical record. He/she indicated that it is the responsibility of the Case Manager to coordinate any discharge equipment needs. He/she indicated the Case Manager should call the physician for an order if there is not an order in the charge for equipment. He/she verified there was nothing in the case management notes for patient #1 concerning a wound VAC.</p> <p>12. Staff member #26 (Program Director for Care Alliance) indicated in interview beginning at 3:00 p.m. on 12/17/15 that all the documents sent to facility #2 for patient #1 were not all the documents required to be sent.</p>			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(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	